North Carolina State Planning Grant

North Carolina Final Report

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Submitted to the U. S. Health Resources and Services Administration
By the North Carolina Department of Health and Human Services

Executive Summary

HRSA State Planning Grant activities commenced in late September of 2004 following the Notice of Grant Award. This grant has provided North Carolina with an excellent opportunity to bring together some of our state's top public policy experts to work with our leading policy makers in developing a plan to cover the uninsured.

Structure: The lead agency for this grant was the North Carolina Department of Health and Human Services (NC DHHS). A Steering Committee comprised of representatives from the Office of Research, Demonstrations, and Rural Health Development (ORDRHD) and the State Center for Health Statistics (SCHS) within the NC DHHS; the Department of Insurance (DOI); the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill (Sheps Center); and the North Carolina Institute of Medicine (NC IOM) plan and coordinate grant activities. Members of the SPG Steering Committee and staff are listed in Appendix III. Two contractors are being used to provide support to this effort. One is providing actuarial services necessary to cost out potential policy and coverage options, while the other conducted focus group research.

Process: The Secretary of the NC DHHS co-chaired a statewide Task Force on the Uninsured under the auspices of the NC IOM. Comprised of our leading policy makers, the goal was to create a consensus around a set of policy options to provide additional health coverage options to currently uninsured North Carolinians. Between February 2005 and January 2006, eight meetings were held. Covering the Uninsured Task Force participants are listed in Appendix IV.

Key Activities: To support our efforts to engage key stakeholders in this deliberative process, the following occurred:

1. Extensive quantitative research was conducted, primarily using existing data bases, including the Current Population Survey's Annual Social and Economic Supplement (ASEC), the Medical Expenditure Panel Survey (MEPS), and the Behavioral Risk Factor Surveillance System (BRFSS). We supplemented the BRFSS with additional questions designed to address additional areas of concern to us. Data extracted was synthesized and used to provide detailed information to the Task Force for purposes of describing characteristics of the uninsured, evaluating trends, and providing analysis for various options being discussed. Baseline information regarding characteristics of the uninsured population and access to insurance coverage are in Appendix I. Key findings of our analysis were as follows:

    - Three-fifths of the uninsured in North Carolina have incomes below 200% of the poverty guidelines.
    - Approximately half of the North Carolina uninsured have a family connection to a small (less than 25 employee) firm.
    - Although premiums for large firms were comparable to those of neighboring states, premiums for small firms were slightly higher.
    - North Carolina firms are less likely to offer insurance to employees; they also pay more, on average.

- Dependent coverage is slightly lower in North Carolina than neighboring states.

These findings led the Task Force to focus on employees of small firms and their dependents and those with low income during their deliberations which ended in January 2006.

2. Focus group research aimed at better understanding individual and employee or employer decisions to accept/reject or offer/not offer health insurance was conducted between March and May 2005 statewide. Areas covered provide insight into issues of affordability, participation, and ideas on how to expand coverage to the uninsured. Findings from these focus groups were conveyed to the Task Force in the summer of 2005. Key findings that were reviewed by the Task Force were:

   - Uninsured individuals desired coverage, but did not think they could afford it.
   - Employers believed health insurance is an important benefit used to recruit and retain a quality staff.
   - However, faced with increasing premiums, employers were cutting back on dependent coverage and limiting the insurance options offered to employees.

3. Examination of options commenced early on in the Task Force meetings and continued through January 2006. A list of presentations made to the Task Force is in Appendix II. The data presented, results of the focus group research, and discussions at these meetings lead the Task Force toward recommending a combination of options, including: Medicaid expansion targeted to low-income families, establishment of a high risk pool for uninsurable individuals, and multiple private options to increase the availability of health insurance through small businesses.

4. The Task Force completed its work and published the findings and recommendations in a report entitled Expanding Health Insurance Coverage to More North Carolinians in April 2006. The report is available at http://www.nciom.org/projects/uninsured/uninsured.html.

Outcomes to Date:

1. The NC IOM presented the principal Task Force recommendations to the North Carolina General Assembly through a series of eight presentations that were made to key committees from December 2005 through June 2006 (Appendix V). Their deliberations, which occurred in a more favorable fiscal climate, produced sufficient consensus to move forward with some of the key components of our plan. These are detailed in Appendix VI.

2. The General Assembly, despite the fact that the second year of a biennium budget is primarily used to make modest adjustments in the budget, addressed these issues and enacted a number of provisions that both encouraged expanding health coverage and provided policy direction to NC DHHS for developing a plan for publicly funded options. These include:

a. Providing a tax credit to small businesses that pay at least 50% of the health insurance premium for employees as a means to encourage more small businesses to offer health insurance to employees.
b. Approving an increase in state funding for safety-net providers from 2 to 5 million dollars to help community based providers to continue serving the uninsured.
c. Directing as well as funding the NC DHHS to finalize a plan to expand health care access to the uninsured and produce a report for legislative action by March 2007.
d. Giving strong consideration in the waning days of this legislative session to the creation of a high-risk pool to provide medically uninsurable North Carolinians an affordable health coverage option. This measure, House Bill 1895, passed the House by a wide margin, but there was insufficient time to consider it in the Senate.

3. The NC DHHS, as a result of legislative action, will conduct the mandated planning activity cited above. The Task Force report provides a blueprint from which the final plan will be developed. There is cautious optimism that further progress on public options to expand access to health care will be made during the next legislative session.

4. Based on Task Force recommendations, the NC DOI convened a workgroup that reviewed small group rating laws. The recommendations of this work group were somewhat technical, but all had the goal of increasing access to health insurance for small employers and removing system inefficiencies which could unnecessarily increase the premium. The recommendations of the workgroup were ratified by the General Assembly in the 2006 session.

Section 1. Uninsured Individuals and Families

Quantitative Research

As anticipated in our State Planning Grant proposal, data analysis has formed an integral element of the process of seeking to expand health insurance coverage in North Carolina. Quantitative data provides important insight into the types of policy options that would be most likely to facilitate expanding coverage in a cost-effective manner. For our analysis, we pulled secondary data from a number of existing databases, including the Annual Social and Economic Supplement (ASEC) of the Current Population Survey [U.S. Bureaus of the Census and Labor Statistics]; the Medical Expenditure Panel Survey (MEPS) [Agency for Healthcare Research and Quality]; the North Carolina Hospital Discharge Database [Cecil G. Sheps Center for Health Services Research]; and the Behavioral Risk Factor Surveillance System (BRFSS) [North Carolina State Center for Health Statistics]. We also contracted with the State Center for Health Statistics to include twelve additional survey questions in the 2005 NC BRFSS that were specifically designed to elicit information not currently available.

Throughout Sections 1 and 2 below, the source of the raw data from which we extrapolated our own conclusions is cited as "ASEC," "BRFSS," or "MEPS" although no individual table or report provided this information unless noted otherwise. A citation at the end of the paragraph refers to all statistics listed in that paragraph. When ASEC data are used, unless the data come directly from a Census website, we use two-year weighted averages, in which more recent data receive a higher weight. Details of this approach are outlined in Appendix F of the Task Force's final report, available at http://www.nciom.org/projects/uninsured/uninsured.html.

This section has been updated to reflect changes in data between years one and two of the grant. This data and qualitative research findings were used throughout year two as part of the Task Force deliberations on options for expanding public and private insurance coverage.

Population Characteristics

There were more than 1.3 million uninsured in North Carolina in 2003, or almost one out of every six (18%) non-elderly North Carolinians. [ASEC] Between 2000-2003, North Carolina had the second largest increase in the numbers of non-elderly people without insurance coverage of any state in the country; more than 330,000 people lost coverage during this four-year time period.[1]

Income

People with incomes less than the federal poverty guidelines (FPG) are the most likely to be uninsured (Table 1).[i] More than 35% of the people living in poverty are uninsured, as compared to 8.5% of those with incomes in excess of 300% FPG. Low income people are less likely to

[1] U.S. Census. Health Insurance Coverage Status and Type of Coverage by State—Persons Under 65: 1987 to 2003 (HI6). Available on the Internet at: http;//www.census.gov/hhes/www/hlthins/historic/hihistt6.html. (Accessed May 17, 2005).

have employer based coverage, and more likely to rely on Medicaid as their source of health insurance coverage. [ASEC]

Table 1. Insurance Coverage by Poverty Status

Insurance Type (Percent of People less than age 65)	<100% FPG (15%)	100-200% FPG (18%)	200-300% FPG (16%)	300% + FPG (50%)	Total (100%)
Employer	**13.2%**	**32.3%**	**61.7%**	**80.1%**	**58.3%**
Medicaid	**35.3%**	**19.7%**	**5.8%**	**2.8%**	**11.3%**
Medicare	**5.8%**	**5.6%**	**3.8%**	**1.3%**	**3.2%**
Private	**10.4%**	**13.1%**	**10.4%**	**7.2%**	**9.3%**
Uninsured	**35.4%**	**29.4%**	**18.3%**	**8.5%**	**18.0%**
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

More than half (54%) of the non-elderly uninsured have incomes below 200% FPG, 18% have incomes between 200-300% FPG and 8.5% have incomes in excess of 300% FPG. [ASEC]

Age/Sex

Young adults are more likely to be uninsured than either the very young or older adults (Table 2). Nearly half (44.8%) of those between the ages of 18 and 34 are uninsured, while less than twenty percent of the other age groups lack health insurance.

Table 2. Percent of Uninsured by Age (ASEC 2003-2004)

Age Group	Percent of the Uninsured
0-17	18.1%
18-24	18.2%
25-34	26.6%
35-44	15.4%
45-54	14%
55-64	7.7%
65 and Over	0%
	100.0%

Males are more likely to be uninsured (20.2% vs. 15.8% of females) and comprise a larger portion of the uninsured (55.7% of the uninsured). [ASEC]

Health Status

The uninsured have lower self-reported health status. Approximately 36.3 percent of the non-elderly uninsured claim good, fair, or poor health status, compared to 23.8 percent of the non-elderly insured. [BRFSS]

We used BRFSS data to identify barriers to care for people without health insurance coverage in North Carolina. Uninsured North Carolinians in the most recent BRFSS survey (2004) were more likely to report that they had no personal doctor or health care provider (52%) than people with insurance (13%), and are less likely to report being in excellent or very good health. They are more than four times more likely to report that there were times in the last twelve months when they needed to see a doctor but could not because of the costs (44% uninsured vs. 11% for people with insurance) and, similarly, uninsured people with diabetes were more likely than those with insurance to report that there were times when they were unable to obtain either testing supplies or medicines due to the costs (49% vs. 16% respectively). Uninsured women are less likely than insured women to report having ever had a mammogram; and of those who had a mammogram, they were less likely to report having a mammogram in the last year (45% vs. 70% respectively). Uninsured adults who were 50 or older were less likely to report ever having a colorectal screening (e.g. sigmoidoscopy or colonoscopy), and uninsured men were less likely to have ever had a PSA test. [BRFSS, 2004]

ESI and Work Status

Employer sponsored insurance (ESI) is the primary source of coverage for 61.5% of North Carolinians, but this source of coverage is rapidly declining. There has been a steady decline in employer sponsored insurance over the last four years (2000-2003) across the country, but North Carolina's loss of ESI has been more than twice that of the national average. Nationally, there was a 6% decline in ESI (from 67.6% to 63.3%); however, there was more than a 9% decline in ESI in North Carolina (from 67.6% to 61.5%). [ASEC]

Most of the uninsured live in a family where a person works full time. About half (44.3%) of the uninsured live in a family where there is one full-time worker, and 33% live in a family with 2 full-time workers. Another 10.5% live in a family with only-part time workers. Only 12.2% of the uninsured live in families with no workers. [ASEC]

More than half of all uninsured workers (52.8%) work for small employers with less than 25 employees. Another 12.1% work for medium-size firms (25-99 employees), and 11.3% work for larger firms (100-199 employees). While most of the uninsured work for small firms, 16.5% of the uninsured work for very large firms with more than 1,000 employees. [ASEC]

According to CPS data from 2004, North Carolinians are almost equally likely to purchase non-group coverage as the national average, with 6.4% of North Carolinians having non-group coverage vs. 6.6% in the United States. [ASEC]

Public Insurance Programs

North Carolina's Medicaid program covered 1,138,352 individuals as of July 2005. Of this number, 412,470 are children; 22,850 are pregnant women; 316,143 are TANF recipients (children and caretaker relatives); 26,531 are aged; 217,882 are disabled or blind; 37,878 are under Medicare catastrophic care; and 4,598 are either in foster care, are refugees, or have breast and cervical cancer.[2] NC Health Choice (SCHIP) covers 134,194 children.[3]

Many eligible people do not enroll in Medicaid. Of the approximately 1.3 million uninsured people in North Carolina, an estimated 192,000 are children, 46,000 are uninsured adults with dependent children, 13,000 are uninsured pregnant women, and 4,000 are uninsured people with disabilities who appear to meet the Medicaid or NC Health Choice income eligibility criteria.[4] Many of these people may be eligible for Medicaid (or NC Health Choice), but have not enrolled in the program. These numbers may be an overestimate of potential eligibles; but it is safe to assume that there are thousands of uninsured individuals who are eligible but not enrolled.

Racial Disparities

Almost half (49%) of the uninsured are white (not Latino), which is comparable to their percentage in the general population. Latinos comprise 21.5% of the uninsured and nonwhite non-Hispanics (about 80 percent of which are African-American) constitute 23% of the uninsured. Racial and ethnic minorities are more likely to be uninsured. More than half (53.6%) of Latinos and 18.4% of non-white, non-Latino are uninsured, compared to 13.6% of white, non-Latino. [ASEC]

The likelihood of being uninsured varies by nation of birth and citizenship, especially for Latinos. North Carolina Latinos are more likely to be recent immigrants born outside of the United States and ineligible for publicly financed health insurance programs. Latino immigrants are more likely to work in industries (such as construction or agriculture) that are generally less likely to offer health insurance coverage. As a result of the combination of lack of public coverage and less access to private coverage, they are disproportionately likely to be uninsured. Latinos born in the United States are about equally likely to be uninsured as non-white, non-Latinos (24.3%); however, Latino citizens born outside the United States are much more likely to be uninsured (39.9%), and those that are non-citizens are most likely to be uninsured (70.4%). [ASEC]

Geographic Factors

The uninsurance rate varies across the state and is dependent, at least in part, on the county's economic base (major industries and employers), unemployment rate, and other socio-economic

[2] Division of Medical Assistance. Authorized Medicaid Eligibles by County. Report Month: July 2005. Available online at: http://www.dhhs.state.nc.us/dma/elig/elig.html (Accessed July, 2005).
[3] Division of Medical Assistance. Active NC Health Choice Clients by County Reported on WD 7385 – July 2005. Available online at: Available online at: http://www.dhhs.state.nc.us/dma/elig/elig.html (Accessed July, 2005).
[4] Holmes M. Presentation to NC IOM Covering Uninsured Task Force, Apr. 2005. Based on 2001-03 CPS data.

factors. The Cecil G. Sheps Center for Health Services Research at The University of North Carolina at Chapel Hill used these factors to develop county level estimates of the uninsured.[ii] In 2004, the uninsurance rate ranged from a high of 28.3% in Tyrrell County to a low of 13.9% in Wake County.

- ✓ *The ten counties with the highest percentage of people without insurance coverage are*: Tyrrell (28.3%), Duplin (26.9%), Hyde (26.2%), Sampson (25.1%), Onslow (24.8%), Greene (24.4%), Alleghany (23.9%), Robeson (23.5%), Warren (23.4%), and Camden (23.1%).

- ✓ *The ten counties with the lowest percentage of people without insurance coverage are*: Wake (13.9%), Mecklenburg (14.8%), Granville (15.0%), Swain (16.0%), Durham (16.1%), Guilford (16.2%), Orange (16.3%), Forsyth (16.3%), Union (16.4%), and Cabarrus (16.5%).

Based on all the above data, the Task Force identified two groups at higher risk of being uninsured, and who comprise the majority of people who are uninsured: those with incomes below 200% FPG and those who work for small employers (with fewer than 50 employees). Trying to identify policy options to expand health insurance coverage to these groups of uninsured became the focus of the Task Force's deliberations in the final months.

Qualitative Research

FGI Research, Inc. conducted 15 focus groups between March and May 2005. Five groups were comprised of uninsured individuals, eight of the groups were either employers or representatives of an employer and two groups were held with insurance agents and brokers. The purpose of these groups was to learn how decisions are made by individuals and employers with regard to seeking and offering health insurance, and what policy options for expanding coverage are favored by each group.

Discussion topics included factors considered in making decisions about take-up or offering health insurance, consequences of being uninsured and/or not offering insurance and the willingness of both individuals and employers to pay for insurance. Participants discussed possible trade-offs in lifestyle or benefits to make insurance more affordable. A number of insurance plans were presented to participants and they examined policy preferences.

Focus group sessions lasted approximately two hours and were tape recorded for accuracy. All tapes were transcribed and analyzed by an external contractor. Sample insurance benefit packages were priced by Mercer Government Consulting Group and were presented according to benefit package design and cost.

Focus groups were held across North Carolina in order to be geographically diverse. In an effort to gain a fair representation of individuals from across the state, groups were held in Beaufort, Cabarrus, Jackson, Robeson and Wake Counties. Uninsured individuals were recruited from a random sample of telephone numbers within a 35-mile radius of the group location. All business representatives were either responsible for managing their company's health care benefits or for

making decisions regarding whether or not to offer health insurance to employees. Employers and their representatives were recruited from listed business sample of specific sizes for each group. Four groups were held with small employers (1-49 employees), two groups with medium employers (25-99), and two groups with large employers (100+). Both large and small employers were recruited within a 35-mile radius of the group location. The recruitment radius was extended to 50 miles for medium size employers in order to obtain sufficient sample size. Participants in these groups represented diverse industries, including agriculture, hospitality, government and construction. Agents and brokers were recruited from listed sample within a 35-mile radius of the group location. To qualify for participation, health insurance had to be a major line of business for their agency and they had to focus on the small group market, the individual market or both. The final focus group report was delivered in August 2005, along with final transcripts from the focus group sessions. The focus group report is available at http://www.nciom.org/projects/uninsured/FGIreport.pdf.

Affordability

Focus group participants were asked how much they would be willing and able to pay for health insurance. Uninsured individuals generally discussed a price point that ranged from $40 to $150 per month out of pocket; however there was no ability to determine what percentage of income these estimates represented.

Participation

Focus group participants demonstrated limited knowledge and understanding of public programs to assist individuals in accessing health care. Uninsured individuals who participated in focus groups identified high premiums as a barrier to participating in employer sponsored health insurance coverage, when such coverage was available. However, many of the participants did not have the option of enrolling in employer-sponsored coverage because they worked for companies that did not offer health insurance.

Focus group respondents were mixed on whether they felt health insurance should continue to be tied to employment. While some felt that health insurance should be based in the private sector and tied to employment, a number of people thought that there should be greater involvement of government in the provision of health insurance. Several respondents commented that employer-sponsored insurance is attractive only if the employer makes a significant contribution towards the insurance. In several focus groups, participants discussed the merits of government taking over health insurance for the whole population. Additionally, respondents discussed the challenges of obtaining health insurance while unemployed because of high COBRA premiums (if even available) and debated the merits of a public benefit program to assist people while they are seeking new employment.

Options Discussed

Focus group respondents were generally interested in the concept of subsidies to purchase health insurance, though the impact would depend on whether the subsidy was meaningful in making health insurance premiums more affordable. Individuals did not express much interest in the

idea of tax credits for health insurance purchases. However, employers did discuss the concept of tax credits in greater length. Several respondents commented that employers already receive tax relief for the provision of health insurance. Employers who are self-insured expressed interest in a state-sponsored reinsurance program to help minimize their risk for rare or expensive health problems among their employee pool.

Cost was the primary factor discussed by individuals as a barrier to purchasing health insurance. Uninsured individuals commonly talked about getting care in hospitals and clinics despite their lack of insurance coverage. Several respondents commented that they felt they either received substandard care, were looked down upon because they did not have insurance coverage, and felt confused about the charges that were incurred during their visits. Numerous respondents discussed the need for standardized prices for health care to address the vagueness in charges and to eliminate the inflation in charges for people who do not have insurance coverage. Several respondents felt they were paying more for the same services that an insured person receives.

Respondents were mixed on the value of a barebones benefit package, primarily because they did not see how an affordable benefit package could provide the coverage they wanted if they were to pay out of pocket.

Section 2. Employer Based Coverage

For most of the analyses of employer-sponsored insurance, we used data from the MEPS Insurance Component data available online from the MEPS website.[5] Because the data can be used to identify individual establishments, AHRQ does not release a micro-level dataset. Although we sought access to the analysis files at the regional Census Data Research Center, ultimately it was not feasible to perform such analyses and we used the published Insurance Component tables available online.

Employer Size

North Carolina small employers (with fewer than 10 employees) are far less likely to offer health insurance coverage than other size firms (Table 3). In North Carolina, only 29.4% of these firms offer health insurance, compared to 67.5% of firms with 10-24 employees,79.3% of firms with 25-99 employees, and more than 90% of larger firms. (MEPS, Table II.A.2 2004). In 2004, North Carolina employers were about equally likely as other employers across the nation to offer health insurance coverage.

Table 3. Small Employers Less Likely to Offer Health Insurance Than Other Size Firms

	Total	<10 employees	10-24 employees	25-99 employees	100-999 employees	1000 + employees
NC	54.2%	33.3%	61.9%	76.0%	93.5%	97.6%
US	55.7%	34.9%	65.1%	81.1%	93.9%	98.8%

Source: MEPS, Table II.A.2 (2003 and 2004 average)

[5] http://www.meps.ahrq.gov/

The agriculture, forestry and construction industries (38.7%) and the retail and other services sectors (49.1%) are less likely to offer coverage than mining and manufacturing (80.0%) or other sectors (66.7%) (Table 4).

Table 4. Employers in Certain Industries More Likely to Offer Health Insurance

	Total	Agriculture, fishing, forestry and construction	Mining & manufacturing	Retail, other services and unknown	Professional services	All other
NC	54.2%	38.7%	80.0%	49.1%	59.8%	66.7%
US	55.7%	41.0%	69.3%	50.5%	60.8%	67.0%

Source: MEPS, Table V.A.2 (2003 and 2004 average)

Cost of Policies

In general, North Carolina premiums are relatively comparable to premiums charged nationally. On average, premiums for employees were approximately $3,289/year for individual employee coverage (2002-2003) or $8,244/year for family coverage (Table 5). North Carolina employees pay about the same share of premiums for individual coverage as nationally, but are generally required to pay more for dependent coverage. This is especially true for small employers (with fewer than 50 employees).

Table 5. Average Premiums at Private-Sector Establishments that Offer Health Insurance

Average Premium	Total (employee share)	< 10 employees (employee share)	10-24 employees (employee share)	25-99 employees (employee share)	100-999 employees (employee share)	1,000 or more (employee share)
Employee Only						
North Carolina	$3,289 ($558)	$3,429 ($242)	$4,154 ($626)	$3,013 ($500)	$3,512 ($546)	$3,097 ($607)
United States	$3,335 ($586)	$3,700 ($452)	$3,438 ($499)	$3,300 ($600)	$3,302 ($598)	$3,280 ($615)
Family Coverage						
North Carolina	$8,244 ($2,235)	$8,739 ($2,013)	$9,901 ($2,665)	$7,989 ($3,167)	$8,034 ($2,805)	$8,197 ($2,006)
United States	$8,859 ($2,135)	$8,944 ($1,906)	$8,823 ($2,441)	$8,869 ($2,768)	$8,721 ($2,395)	$8,895 ($1,942)

Source: Agency for Healthcare Quality and Research. Medical Expenditure Panel Survey. Insurance Component Tables II.C.I., II.C.2., II.D.1, II.D.2 (2002 & 2003)

Participation of Employees

With the exception of very small employers (under 10 employees), North Carolina employers are about equally likely to offer health insurance coverage as their national counterparts. North Carolina employees are about equally likely to be eligible for coverage and be enrolled in

coverage than other employees nationally. The problem in North Carolina appears to be concentrated in the very smallest employers, who are less likely to offer coverage (Table 6).

Table 6. Employees Eligible for Coverage, Eligible Who Are Enrolled, and Percent of All Private Sector Employees Enrolled In Firms that Offer Insurance (2002-2003)

	Total	< 10 employees	10-24 employees	25-99 employees	100-999 employees	1,000 + employees
Eligible for Coverage						
NC	81.5%	87.9%	83.3%	75.1%	80.9%	82.2%
US	77.8%	81.7%	78.1%	74.5%	75.7%	78.9%
Percent of Eligible who are Enrolled in Coverage						
NC	83.4%	86.2%	79.8%	78.4%	85.5%	83.8%
US	80.7%	80.0%	77.6%	77.5%	79.7%	82.3%
Percent of All Private Sector Employees Enrolled in Coverage in Firms that Offer						
NC	68.0%	75.7%	66.4%	58.9%	69.1%	68.8%
US	62.7%	65.4%	60.6%	57.7%	60.3%	64.9%

Source: Agency for Healthcare Research and Quality. Medical Expenditure Panel Survey. Insurance Component Tables II.C.3, II.D.3 (2002-2003)

These data shaped the interest of the Task Force to examining employer sponsored health insurance in the small employer market. Task Force members have interpreted the data as suggestive that the primary problem is encouraging employers to *offer* insurance. Those employees that are offered coverage tend to enroll, and the employee's share of the premium (as a percent) tends to be comparable to other benchmarks. In year two, the Task Force formulated and refined policy options that would address this feature of the ESI market.

Qualitative Research

Focus groups, while not a way to gather information that is scientifically representative of the population, allow us to gather impressions and ideas from those who attend. The employers who came were, for the most part, employers from small firms. These are the ones who are having the most difficulty in finding affordable coverage. A common theme among employers was that health insurance is an important employee benefit, and to be competitive in their industry, it is desirable to offer it. However, increasingly, they are having trouble with the affordability.

Like uninsured individuals, employers discussed cost as the main factor in deciding whether to offer health insurance coverage to employees. Small employers also raised concerns about insurance carrier requirements for minimum participation and 50% employer contribution, which they felt kept them from offering coverage to any employees because they could not guarantee participation among their workforce and could not necessarily afford it.

Most employers described an earnest interest in providing comprehensive benefits to employees, but felt they could not afford to do so. In fact, many employers discussed their recent need to scale back benefits or increase cost sharing because of premium increases. Employers explained

that increases in premium costs were forcing them to redesign benefit packages, increase cost sharing, and consider eliminating health insurance benefits altogether. Employers did express some interest in tax incentives, though several commented that beneficial tax policies already exist for employers to provide health insurance coverage.

Section 3. Healthcare Market Place

The healthcare market place in North Carolina with respect to health insurance is a mix of private insurers and State/Federal insurance programs. The private market is composed of several large insurance companies, and a number of smaller entities. HMO coverage has been steadily declining since 1998. PPOs are the predominant type of insurance coverage. The public market consists primarily of Medicare, Medicaid and Health Choice, and their coverage is mostly fee-for-service with some managed care. Information about the North Carolina marketplace was gathered from reports and websites of the private and public programs. We noted no significant changes between year one and two of the grant period.

Adequacy

Non-group coverage is more costly than employer-based health insurance. The largest insurer in the non-group market provides insurance to any individual, regardless of health status or preexisting conditions. However, premium costs vary considerably depending upon the person's age, health status, county of residence, and chosen plan coverage. For example, the premium costs for a comprehensive benefit package ($250 deductible, 80/20 coinsurance) for a 35 year old man could range from approximately $1,680-$15,600/year, depending on health status and residence (Source: www.bcbsnc.com) . That same policy for a 55 year old man could range from $4,200-$36,000/year. A higher deductible plan with more cost sharing ($1,000 deductible, 70/30 co-insurance) would range from approximately $1,320-$12,000/year for a 35 year old man to between $2,880-$26,400/year for a 55 year old man. Premium costs for a woman are higher, especially if the woman selects maternity coverage.

Choices of insurance products are available in North Carolina to most group and individual subscribers. However, those with significant pre-existing health care problems may only have one option, that being a BCBSNC product. Though most persons have options, if one defines "adequate" products as those that are affordable, there is evidence from the focus groups that we do not have such products in this state. The consensus of the uninsured members of the focus groups was that the insurance products available to them, either through an employer's or an individual product, were not affordable.

Variation in Benefits

There are literally thousands of configurations of health benefit packages in North Carolina. The individual market products may be more standardized by the insurers, but the group plans, particularly the large group and self insured, are tailored to the desires of the employer. The most prevalent coverage in North Carolina is a preferred provider product. HMO products are less popular, and membership is declining annually.

Based on the policy forms that are filed with the Department of Insurance, there is not any notable difference in benefits and coverage options available to individuals, small groups and large groups, except for the fact that deductibles tend to be higher and lifetime maximums lower in the non-group (individual) market than with other group plans. There are a few mandated benefits that apply to large and small group plans (e.g., insurers must offer chemical dependency coverage to groups), but for non-group coverage these are relatively minor. We do not have information about the benefit plans offered under self-funded employers, so we cannot comment on how this segment of the health plan market compares to the insured segment.

Self-Insured Firms

In North Carolina, 67.8% of private sector enrollees are enrolled in self-insured plans at establishments that offer health insurance, compared to 56.1% nationally. This may be because a higher percentage of North Carolina employees work for very large firms with 1,000 or more employees (47% of NC private sector employees vs. 45.9% nationally) and employees in these firms are more likely to be enrolled in a self-insured plan (92.7% in NC vs. 83.2% nationally). (MEPS, Tables II.B.1.a and II.B.2(1) (2003))

The largest of the self-insured plans are more likely to be national accounts. That is, these groups have a presence in multiple states. If North Carolina is not their headquarters, decisions on health care coverage will be made outside of North Carolina. This limits the ability for local policy to influence coverage decisions.

State as Purchaser of Health Care

The State covers approximately 15% of North Carolinians through Medicaid and NC Health Choice and another 7% through the Teachers and State Employees' Comprehensive Major Medical Program ("State Employees Health Plan"). However, to date, the State has not combined the purchasing power of these programs.

Medicaid has helped improve the quality of care provided to Medicaid recipients, with positive spill over effects on care provided to the uninsured and other people with insurance coverage. Medicaid recipients with certain chronic or high-cost health conditions receive care coordination and disease management services through Community Care of North Carolina (CCNC). CCNC consists of community networks of primary care providers, hospitals, departments of social services, and health departments that provide disease management and case management services to help patients manage chronic or high-cost health conditions.[iii] There are currently 14 regional networks covering over 700,000 Medicaid recipients in all counties. The initial results of this initiative have been promising, both in terms of improved clinical care and reduced health expenditures. As a result, the General Assembly in the 2005 session instructed the Department of Health and Human Services to expand the program to the dual eligibles and to children enrolled in NC Health Choice. (North Carolina has historically operated a separate SCHIP program; the services are provided through the State Employees' Health Plan so this population has not heretofore been enrolled in CCNC.)

Evaluation of Safety-Net Providers

The NC IOM examined the adequacy and financial viability of North Carolina's Health Care Safety-Net in 2004. The study was able to quantify that only about 25% of the uninsured in the state receive primary care services from a FQHC, local health department, free clinic, state-funded rural health clinic, AHEC residency clinic, or other non-profit providing care to the uninsured. The Safety-Net Task Force's final report is available at http://www.nciom.org/projects/SafetyNet/safetynetreport.html. Key recommendations made to NC DHHS by the Safety-Net Task Force are included in the Appendix VII. The information from the Safety-Net Task Force was shared with the Task Force on Covering the Uninsured. In addition, there was significant overlap of members on both these Task Forces, with representatives from several safety net organizations serving on the Covering the Uninsured Task Force as well. Realizing the process of achieving incremental improvements in coverage will take some time, the need to continue to focus attention on strengthening the safety-net is an important component of our state's strategy. The Covering the Uninsured Task Force reiterated this fact in their recommendations.

Consideration of Other States' Experiences

The Steering Committee and staff synthesized various policy options collected from other states and discussed at the SPG national meetings and presented this information in Task Force meetings. This information was used in the deliberations about different policy options to expand coverage to the uninsured during both years of the grant. Specifically, staff gathered information on publicly-funded expansion options, high risk pools, and public-private partnerships focused on expanding coverage to small employers.

Publicly-funded options: We examined what other states have done to expand Medicaid coverage to the uninsured, including outreach and simplification (to facilitate enrollment of people who are currently eligible), income levels for coverage of children and parents, and waivers to develop limited benefit packages. One of the work groups of the Task Force used this information to identify ways in which North Carolina could increase its outreach and simplification activities. We also explored the possibility of designing a limited benefits package that could be offered through an 1115 waiver to low-income parents.

High risk pools: There are currently 34 other states that have high risk pools; North Carolina is one of a minority of states that does not yet have a high risk pool. We used information from other states to identify policy options that must be addressed in designing a similar product for North Carolina (for example, caps on premiums, how the high-risk pool would be financed, and premium subsidies for low-income families).

Public-private partnerships for small employers: The Task Force considered other states' experiences with public/private partnerships. Specifically, the Task Force favored a North Carolina version of the Healthy New York reinsurance model. They also followed Kansas' reinsurance initiative with keen interest, but it is still too early to draw lessons from their experience.

The North Carolina General Assembly is actively considering both approaches. The NC Senate considered legislation to develop a Healthy North Carolina reinsurance plan and the House has introduced several pieces of legislation to consider a high-risk pool (H180, S534, H1535). These issues will be studied further during the short-session and will be revisited during the 2007 legislative session.

The NC Department of Insurance contacted the National Association of Insurance Commissioners to determine if any states had made major revisions to their small group rating reform laws in the last few years. Unfortunately, there were no systematic data about other states' experiences or changes in small group reform (and specifically, adjusted community rating bands).

The Task Force also learned about other states' experiences in developing "pared-down" benefit packages; and the flexibility that would be needed to develop mandate-light insurance products.

Section 4. Options for Expanding Coverage

Early in the Task Force's deliberations, we presented a range of policy options for the Task Force to consider. We began meeting in February 2005, and spent the first day presenting information on the uninsured (demographics of the uninsured, reasons for lack of coverage, and health consequences of being uninsured). However, by our second meeting (March 2005), we began discussing policy options. Consultants from Mercer presented an overview of private options, publicly-funded options and public/private partnerships. Specifically, they presented information on:

- ✓ Private sector approaches: managed care, major medical/catastrophic plans, consumer directed health plans, limited benefits packages, and purchasing pools.
- ✓ Publicly-funded options: Medicaid expansions, high-risk pools, and safety-net options.
- ✓ Public-private partnerships: Three-share programs, premium assistance, tax credits, reinsurance, and state employee plan buy-in.

More detailed information about some of these approaches was presented in subsequent meetings (April, June and July 2005). The Task Force also heard presentations from consultants about the results of focus groups with employers, uninsured individuals and insurance brokers about policy preferences (July 2005).

Based on the data of the uninsured in North Carolina, and the focus group results, the Task Force focused throughout year two on developing and refining its work on three primary sets of policy options: Medicaid expansion, high-risk pools, and private options to expand coverage to small employers. The Task Force recommended four health insurance products and programs, three of which were designated as priority.

1) **Expanding Medicaid to cover more uninsured individuals (Priority)**. The Task Force recommended an expansion to parents and pregnant women up to 200% FPG. The Task Force recommended the State seek a §1115 waiver to allow a more limited benefits

package. The plan would allow for premium assistance programs. Eligible individuals would be given the option of enrolling in Medicaid, or using Medicaid funds to pay for their premiums for employer sponsored or non-group insurance (as long as it was cost effective to the State to do so). The recommendation also included a provision that the State cover the counties' share of the expansion.

In addition to the expansion, the Task Force recommended expanding outreach and simplification to encourage Medicaid and NC Health Choice (SCHIP) eligible individuals to apply and maintain their coverage. Data from the Current Population Survey suggests that there may be more than 100,000 uninsured individuals who currently meet the categorical and income requirements for Medicaid or NC Health Choice but are not enrolled. The Task Force recommended increasing the number of out-stationed eligibility workers; simplifying the adult application form; eliminating the asset (resource) test for low-income parents; expanding the eligibility certification period from six months to 12 months; and streamlining the recertification process.

There are several factors that work in favor of Medicaid expansion: 1) Leveraging federal funds to help pay for the coverage expansion; 2) Strong support for Medicaid among the provider community; and 3) Support in the NC General Assembly for Medicaid's primary care case management program (Community Care of North Carolina) that combines disease management and case management delivered through community-based networks of care. The primary barriers to Medicaid expansion are the cost and the fear among state legislators of enacting a new entitlement program.

2) **Establish a high-risk pool (Priority)** North Carolina does not currently operate a high-risk pool. Blue Cross Blue Shield of North Carolina does offer non-group coverage on a guarantee issue basis, but they charge the individual up to seven times the standard rate, depending upon the person's health status. The high risk pool would be financed through a broad assessment on all covered lives of all insurers, reinsurers, MEWAs, TPAs, and ASOs The premium would be capped at 150% of the standard risk, and the State should finance a premium subsidy for those with incomes below 300 percent of FPG.

3) **Establish a Healthy North Carolina program, closely modeled after Healthy New York (Priority).** This program would include the offering of a basic health insurance benefit package to an eligible population and a state-sponsored reinsurance program. Like Healthy New York, eligibility would be limited to small businesses, individuals, and sole proprietors. Small businesses would be eligible if at least 30 percent of its employees earned less than $12, it employs fewer than 25 employees, and it has not offered health insurance in the previous 12 months. Uninsured individuals and the self-employed would be eligible if they are ineligible for employer sponsored insurance, Medicare, or Medicaid and earn less than 250% FPG. The State would provide reinsurance sufficient to reduce the premium by 30 percent.

4) **Encourage the development of tiered benefit programs.** One recommendation was that health plans develop tiered benefit plans, allowing individuals to contribute more to the monthly premium to receive greater coverage than that provided by the employer. An

additional recommendation was for the NC General Assembly to provide the Department of Insurance the flexibility to approve such plans.

The Task Force also recommended the Department of Insurance convene a workgroup to review current small group rating laws and consider whether the current rating system could be modified to allow greater insurance coverage.

One priority recommendation recognized that until all North Carolinians have health insurance coverage, the healthcare safety net will continue to fulfill a vital role in providing healthcare to the uninsured. Thus, the Task Force recommended the NC General Assembly appropriate funds to support the safety net.

The final priority recommendation addressed individuals' role in acting as stewards of their own health, including following healthy lifestyles. Individuals should lead healthy lifestyles, businesses should offer worksite wellness programs. Providers should counsel employees on the importance of healthy lifestyles and insurance companies should offer discounts on premiums for those with healthy lifestyles.

Section 5. Consensus Building Strategy

The North Carolina State Planning Grant project was led by a smaller Steering Committee (Appendix III) comprised of the different state agencies involved in the project: the Office of Research, Demonstrations, and Rural Health Development (ORDRHD) and the State Center for Health Statistics (SCHS), within the North Carolina Department of Health and Human Services (NC DHHS); the NC Department of Insurance (NC DOI); the Cecil G. Sheps Center for Health Services Research at The University of North Carolina at Chapel Hill (Sheps Center); and the NC Institute of Medicine (NC IOM). The ORDRHD provided overall leadership, direction and coordination of activities. The SCHS collected and analyzed state-level data on insurance coverage, ability to access health care and out-of-pocket costs. NC DOI assisted in identifying policy options to reduce health insurance costs and to expand coverage in the private market. The Sheps Center collected and analyzed the existing data on the uninsured from the Current Population Survey and Medical Expenditure Panel Survey. In addition, the Sheps Center had a contract with FGI to conduct focus groups of small and large employers, insurance agents/brokers and the uninsured to find out more about their willingness to pay, the policy options that are most attractive, and the trade-offs that may be reasonable to make health insurance coverage more affordable. The Sheps Center also had a contract with Mercer to develop cost-estimates of different cost-containment options as well as different models to expand coverage. The NC IOM had primary responsibility for convening a Task Force to study the data on the uninsured, and to develop policy options to expand coverage.

Each of the participating organizations helped identify members to serve on the NC IOM Task Force on Covering the Uninsured. The Task Force was comprised of 55 members (Appendix IV), including state and local policy makers (legislators, county commissioners, and representatives of state and local agencies), business leaders (small and large employers), health care providers, insurers and agents, consumer groups, community leaders, and representatives of the faith community. The Task Force was led by the Honorable Carmen Hooker Odom,

Secretary of the NC Department of Health and Human Services, and by Tom Lambeth, retired Executive Director of the Z. Smith Reynolds Foundation in North Carolina. The Governor's Office also participated in the Steering Committee and in each of the Task Force meetings.

All of the information from the Task Force is available on the NC IOM web page at http://www.nciom.org/projects/uninsured/uninsured.html . Issue briefs focusing on specific aspects of the uninsured as well as policy options were developed and distributed widely. In addition, there was considerable media coverage of the Task Force Recommendations. Subsequently, the NC IOM in particular was consulted for other stories on health insurance, and some of this news coverage in turn referred to the recommendations of the Task Force.

The process of pulling together key governmental, provider and advocacy organization representatives into a Task Force setting allows for a thoughtful and deliberative evaluation of the problem of lack of health insurance coverage to North Carolinians. This gave rise to practical options with the greatest potential for resulting in a substantive set of policy recommendations that can be supported by the Task Force member organizations as they are carried forward through the legislative process.

Much of what can be achieved will be predicated on the economic recovery of the State. While we were able to maintain Medicaid funding at current levels during the recent legislative session, the State's continuing fiscal health is dependant upon a strengthening economy generating sufficient revenue to support needed reforms such as those that were put forward.

Section 6. Lessons Learned

A combination of both quantitative and qualitative research that provided our leadership with the best possible information for decision-making was a critical foundation piece. The data collection activities described in previous sections were used to explain both similarities and differences between North Carolina and the US and as accurately as possible focus our attention on sub-populations that are adversely affected by lack of insurance.

The process of further data collection and refinement of our analysis occurred during year two as the Task Force focused on each of the priority areas that it deemed important for inclusion. The availability and use of state specific data coupled with information about other states' programs was an invaluable resource.

The use of the NCIOM and its' Task Force format provided an excellent forum for bringing together a diverse cast of our state's leadership from both the public and private sector. The deliberations, resulting report and presentations to the legislature created the right environment for passing important legislation that will make a difference. It also created forward momentum to take up these issues in the upcoming session.

Section 7. Recommendations to the Federal Government

The options selected and recommendations made by the Task Force do not require changes in federal laws to enact. The passage of the Deficit Reduction Act of 2005 provides additional

flexibility in Medicaid which may make it easier to implement some of the changes recommended in public insurance programs. Supportive efforts by the federal government to sustain funding for continuation of this activity would help us to sustain a forward movement toward attaining the goal of providing health coverage to the uninsured. Continuation funding for the State Coverage Initiatives activities to maintain a national clearinghouse and act as a resource for information on state activities would be helpful.

Section 8. Overall Assessments of SPG Program Activity

North Carolina is rebounding from several years of operating within a difficult state fiscal environment in which cuts were made in state government programs and services to balance the state budget. However, despite these circumstances, the primary goal of maintaining necessary funding levels to sustain programs like Medicaid and Health Choice without instituting major benefit cuts or permanently disenfranchising those currently eligible was met. As NC emerges from several years of coping with annual fiscal shortfalls, the timing is good to assess what appropriate investments and opportunities are available and affordable for the future. If history is some indication of what may occur, we note that in healthier fiscal times the needs of uninsured populations were incrementally addressed through adoption of Health Choice in 1998 and expansion of Medicaid to cover the aged, blind and disabled to 100% of the federal poverty level in 1999. These changes provide an additional 130,000 children and 35,000 adults with access to public insurance programs annually. During the recent legislative session, the General Assembly, faced with the first budget surplus in many years, started to focus its attention toward evaluating both public and private options to assess needs and develop legislation that will take incremental steps to help address the lack of access to health care faced by the uninsured. Execution of the State Planning Grant funded by HRSA was the key element and primary impetus for this state to make substantive gains this legislative session. Without it, NC would not have embarked on an extensive research and planning activity to focus the attention of government and private sector leaders on this issue and develop a consensus approach that enjoys support from a significant mix of our state's leadership.

As explained in previous sections of the report, legislation has been passed that dealt with some components of the plan. Other recommendations of the report that will be addressed are as follows:

1. By March 2007, NC DHHS must finalize and submit an expansion plan. The goals of the plan as enacted are to address ways to: "Aid small businesses that want to provide health coverage, expand health coverage to working uninsured persons, secure available federal funds to support the program and promote charity care by health care providers." In putting together this plan, NC DHHS will draw from findings and recommendation of the Task Force and will evaluate the use of a Medicaid 1115 waiver as well as other options that are available through the Deficit Reduction Act of 2005. We are cautiously optimistic, assuming the fiscal picture remains good, that additional legislation will be enacted to further address providing access to care for populations who currently are uninsured and that the likely target population will be working uninsured persons.

2. Considerable interest was expressed by the General Assembly in creating a Healthy North Carolinian Program similar to the New York plan. It is intended to provide an incentive for health insurers to offer more affordable products to small businesses by funding a reinsurance plan. It would be targeted to small businesses (less than 50 employees) for lower income persons (incomes less than 250% of FPL). Based on interest expressed during this session, we anticipate this program will be considered during the next legislative session.

3. Several public option proposals do not require legislative action and can be implemented through administrative changes. A priority option that could have a significant impact on reducing the number of uninsured is to increase efforts through outreach and administrative simplification efforts to identify, reach out to, and encourage potentially eligible persons to enroll and then simplify re-certification processes to ease continuation of benefits for these enrollees. It is anticipated that NC DHHS will continue and perhaps expand these efforts over the next several years.

Factors that will affect whether and to what extent these recommendations are realized include: 1) whether the economic recovery continues and hopefully accelerates over the next 2 years; 2) the extent to which an appropriate balance can be struck between the goal of fiscal restraint on one hand and the growing problem presented by not addressing the lack of affordable health care options for too many NC citizens; and 3) the extent of actual Medicaid growth in relation to expected growth for the next fiscal year.

With regards to the structure and process employed to complete the state planning grant activities, North Carolina is fortunate to have a plug and go operation. By that we mean through legislation NC established the NC Institute of Medicine in 1983 for the purpose of providing "balanced, nonpartisan information on complex and often controversial health issues in our state." The Task Force format and available expertise and leadership through this body is consistently tapped by both the General Assembly and the administration to tackle difficult problems. Likewise, the Cecil G. Sheps Center for Health Research at the University of North Carolina at Chapel Hill has the expertise, resources and reputation as a top drawer public policy research center. They frequently support public agencies in addressing complex policy issues affecting programs administered by the State. With adequate financial resources, state agencies can and do rely on both of these institutions to consistently provide the best possible products. Finally, since the administration of health programs and regulation of insurance programs are the responsibility of two different state departments, one within the governor's cabinet and one independently elected, it was critical to have both departments provide staff for active participation on the Steering Committee and as members of the Task Force.

The use of the two organizations above reduced our need for technical support for data collection and analysis of that data by technical support services offered through this grant. Our team could independently collect and mine the data sources and interpret the results. However, we had needs for assistance in determining what relevant activities were occurring in other states. The State Coverage Initiatives project staff helped link us to them and provided timely information through issue briefs that examined different approaches to addressing issues of concern to us. We appreciated the excellent information available through the State Coverage Initiatives website on

a range of issues that states which embark on this kind of an activity need to know about. The national SPG project meetings were extremely helpful, particularly at start-up. We were also appreciative of the ability to have input in setting the agenda for these meetings. HRSA staff were knowledgeable, supportive, responsive, timely and available when we had questions or needed additional guidance.

APPENDIX I: BASELINE INFORMATION

Please provide the following baseline information about your State (if possible). Also include any additional baseline information especially relevant to your coverage expansion strategies:

Population: In July 2005, there were an estimated 8,663,674 people in North Carolina. (Source: State Demographics. NC Office of State Budget and Management. Project Annual County Population Totals: 2005-2009.)

Number and percentage of uninsured (current and trend):

Year	Number Uninsured	Annual Increase	Percent Uninsured	Annual Increase
2000	979,692		13.0%	
2001	1,166,694	19.1%	14.4%	10.6%
2002	1,367,573	17.2%	16.8%	16.3%
2003	1,423,649	4.1%	17.3%	3.0%
2004	1,321,568	-7.2%	15.7%	-9.1%
Trend: 2000-2004		34.9%		20.3%
Average	1,251,835		15.4%	

(All individuals including elderly. Source: 2001-2005 ASECs)

Average age of population: Average age in 2005 was 35.8. (Source: 2005 ASEC)

Percent of population living in poverty (<100% FPG): In 2004, 14.7% of the population had incomes below 100% of FPG. (Source: 2005 ASEC.)

Primary industries: Industries with the most full time workers in 2004 included health and education (21%), manufacturing (21%), trade (13%), and construction (11%). The number of full-time workers in construction rose 21% from 1999, while the number of full-time workers in manufacturing fell 34 percent from 1999. (Source: 2005 and 2000 ASEC.)

Number and percent of employers offering coverage: In 2003, 56.5% of employers (approximately 100,000 private employers) offered employees health insurance. (Source: MEPS IC 2003, Tables IIA1 and IIA2.)

Number and percent of self-insured firms: In 2003, 35.1% of employers (approximately 62,000 private employers) self-insured their employees' health insurance plans. (Source: MEPS IC 2003, Tables IIA1 and IIA2a.)

Payer mix:

Insurance Type	Number
Employer	4,452,718
Medicaid	825,999
Medicare	1,124,668
Private	706,536
Uninsured	1,321,568
Total	8,431,489

(Source: 2005 ASEC)

Insurance market reforms: North Carolina implemented small group reform in the early 1990's, including guaranteed availability and renewability and limits on pre-existing conditions, and later amended its laws in order to comply with HIPAA. Guaranteed issue requirements are met by carriers offering all or two representative products. All small group carriers are also required to guarantee issue two statutory plans, known as the Basic and Standard plans. The Basic Plan is exempt from most State mandated benefits and it represents only a small fraction of the small group market. The small group market includes self-employed individuals, with small group being defined as those with 1 to 50 employees, but guaranteed issue for groups of 1 is limited to the Basic and Standard plans. North Carolina included rating restrictions in its small group reforms. Small group carriers must rate each small group using adjusted community rating (adjusted for age and gender of covered person, number of family members covered, and geographic location), with the ability to apply rate bands of +/- 20% upon initial issue and +/-15% upon renewal. Small group carriers have the option of participating in a small group reinsurance pool, and participating carriers can cede entire groups or individual lives; this pool is utilized by only a few carriers. North Carolina does not have a high-risk pool for individuals, or have any other requirements directed at availability.

Eligibility for existing coverage programs (Medicaid/SCHIP/other): In July, 2005 there were 1,138,352 people receiving Medicaid. They were eligible under the following categories:

- ✓ Aged: 26,531
- ✓ Blind: 1,911
- ✓ Disabled: 215,971
- ✓ TANF: 316,143
- ✓ Foster Care: 4,159
- ✓ Pregnant women: 22,850
- ✓ Infants and Children (Poverty-related groups): 412,470
- ✓ Medicare Catastrophic: 37,878
- ✓ Refugees/Aliens: 329
- ✓ Breast/Cervical Cancer: 110

In addition, there were 129,359 children receiving NC Health Choice (SCHIP) in North Carolina during July 2005.

Analysis of 2001-2003 CPS data suggest, that of the approximately 1.4 million non-elderly uninsured in 2003, more than 200,000 may be eligible for Medicaid or NC Health Choice, but not enrolled. This includes:

- ✓ 192,000 uninsured children
- ✓ 46,000 uninsured adults with dependent children
- ✓ 13,000 uninsured pregnant women
- ✓ 4,000 uninsured people with disabilities

Use of Federal Waivers:

North Carolina does not have a §1115 waiver. However, the state does operate a number of other federal Medicaid waivers, including:

- ✓ Family planning waiver. Initially approved November 5, 2004.
- ✓ Community Care of North Carolina (originally called Access), North Carolina's primary care case management program. It was initially approved as 1915(b) waiver in 1991.
- ✓ Piedmont Cardinal Health Plan. Mental health managed care waiver. Initially approved as a 1915(b) waiver on October 6, 2004.
- ✓ Community Alternatives Program for Disabled Adults (CAP/DA). A 1915(c) home and community based waiver that was initially approved on September 28, 1998.
- ✓ Community Alternatives Program for Children with Complex Medical Conditions (CAP-C). A 1915(c) home and community based waiver that was initially approved on June 30, 2000.
- ✓ Community Alternatives Program for People with Mental Retardation or Developmental Disabilities (CAP-MR/DD). A 1915(c) home and community based waiver that was initially approved on March 27, 2001.
- ✓ Community Alternatives Program for People with HIV/AIDS. A 1915(c) home and community based waiver that was initially approved on December 18, 1998.

APPENDIX II: LINKS TO RESEARCH FINDINGS AND METHODOLOGIES

All of the presentations made to the NC IOM Covering the Uninsured Task Force, minutes from each of the Task Force meetings, and the Task Force Final Report are available on the Internet at http://www.nciom.org/projects/uninsured/uninsured.html . The following are a list of documents available on this site:

Data on the Uninsured in NC and Insurance Coverage

Employer Sponsored Insurance in North Carolina
Mark Holmes, PhD - June 24, 2005

The Low Income Uninsured in North Carolina
Mark Holmes, PhD - April 22, 2005

The Impact of Premiums and Cost Sharing on Take-up Rates and Use of Services
Mark Holmes, PhD - April 22, 2005

Overview of the Uninsured
Mark Holmes, PhD - February 24, 2005

The Impact of Being Uninsured on Health Status
Kevin Schulman, MD, MBA - February 24, 2005

Policy Options

Encouraging Responsibility for Health and Wellness
Barbara Morales Burke, MHA - August 11, 2005

Focus Group Results
Kathleen Holladay - July 15, 2005

Public Options to Expand Health Insurance Coverage
Pam Silberman, JD, DrPH - July 15, 2005

Review of Private Insurance Options
Pam Silberman, JD, DrPH - June 24, 2005

Actuarial Analysis of Public Insurance Options
Tim Doyle, FSA, MAAA and Stacey Lampkin, FSA, MAAA - June 24, 2005

Making Health Care Work in North Carolina: The IEI Reform Agenda
Michael Sparer, PhD - April 22, 2005

Public Options to Expand Health Insurance Coverage
Pam Silberman, JD, DrPH - April 22, 2005

Private and Public Private Options to Expand Coverage to the Uninsured
Pam Silberman, JD, DrPH - April 22, 2005

Overview of Sources of Health Insurance and Health Care for the Uninsured
Pam Silberman, JD, DrPH - March 18, 2005

Different Approaches to Expanding Health Insurance
Jeff Smith and Stacey Lampkin, FSA, MAAA - March 18, 2005

Potential Evaluation Criteria
Pam Silberman, JD, DrPH - March 18, 2005

State Planning Grant Overview
Pam Silberman, JD, DrPH - February 24, 2005

Exploring Pathways to Increasing Coverage: Information Support to the Task Force
Sandra Greene, DrPH - February 24, 2005

Healthcare Costs

Drivers of Rising Healthcare Costs
Sandra Greene, DrPH - March 18, 2005

Statistical Analysis and Methodologies

Expanding Health Insurance Coverage to More North Carolinians - North Carolina Task Force on Covering the Uninsured: April 2006; Appendix F: Methodology
Mark Holmes, PhD - April, 2006

APPENDIX III: STATE PLANNING GRANT FOR COVERING THE UNINSURED STEERING COMMITTEE AND STAFF

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APPENDIX IV: NC IOM TASK FORCE ON COVERING THE UNINSURED MEMBERS

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Secretary
N.C. Department of Health and Human Services
Co-Chair of the Task Force

Mr. Thomas Lambeth
Co-Chair of the Task Force

Members:

Rep. Jeff Barnhart
NC General Assembly

Andrea Bazan-Manson, MSW, MPH
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NC General Assembly

Ann Holton
Pamlico County Commissioner

Rep. Verla Insko
NC General Assembly

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NC Association of Free Clinics

David Moore, CLU
Past President
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APPENDIX V: RECOMMENDATIONS OF THE NC IOM COVERING THE UNINSURED TASK FORCE (PRIORITY RECOMMENDATIONS ARE LISTED IN BOLD)

1. The NC General Assembly should help support and expand the existing healthcare safety net to be able to meet more of the healthcare needs of the uninsured.

Role and Responsibility:
Providers (provide care to the uninsured) and
Government (NC General Assembly appropriate funding to support and expand safety net). (Rec. 1.1)

2.
- **a) Individuals have a responsibility to understand their health needs and risks and to be better stewards of their own health. To promote healthy lifestyles:**
  - **i) Individuals should be given the education, support, and resources needed to make informed healthy lifestyle choices, and they should use these resources to make healthy choices.**
  - **ii) Individuals with chronic diseases should be provided information and access to health services in order to manage their health conditions in a manner consistent with best known evidence-based care.**
  - **iii) Individuals who engage in risky health behaviors (such as smoking, sedentary lifestyles, or abuse of drugs or alcohol) should be expected to pay differential premiums to cover some of the increased healthcare costs of their unhealthy lifestyle choices.**
- **b) Providers, employers, insurers, schools, and government should work together to promote healthy lifestyle choices and encourage people to participate in evidence-based wellness initiatives.**
  - **i) Insurers should develop insurance products with financial incentives that reward healthy lifestyle behaviors and should cover wellness-related services (such as smoking cessation) as a basic benefit.**
  - **ii) Providers should educate individual patients and, where appropriate, their family members, about the importance of lifestyle choices in maintaining optimal health; provide information and referrals to help patients engage in healthy behaviors; and provide patients with the information and skills needed to manage chronic disease conditions.**
  - **iii) Employers should, to the extent possible, establish policies and environments that support positive behaviors (i.e., access to healthy food in vending machines and cafeterias, ensuring a tobacco-free environment, encouraging activity at work) and offer wellness programs to engage employees in health awareness and improvement programs in the workplace.**
  - **iv) Schools should also establish healthful policies and environments, including healthy food in cafeterias; opportunities for all youth to be active daily at school; tobacco-free policies;**

and educational opportunities to teach students the importance of healthy lifestyles to maintain optimal health.

v) Public health should continue and expand community-wide health awareness, promotion, nutritional information, and disease prevention activities.

vi) Communities and governments should help support healthy communities by providing environments conducive to healthy lifestyle choices (including, but not limited to, walkways, bicycle paths, safe parks, and green spaces).

c) The NC General Assembly should adequately fund the public health system and infrastructure to provide community education and outreach related to lifestyle choices as well as health promotion and disease prevention, in accordance with the recommendations reported in the Public Health Improvement Plan developed by the NC Public Health Task Force (2004).

Role and Responsibility:
Families: Families should lead healthier lifestyles or pay for increased costs.
Business: Employers should offer worksite wellness programs.
Providers: Providers should counsel patients on the importance of healthy lifestyles.
Insurance: Insurers should offer premium discounts for healthy lifestyles.
Government: The NC General Assembly should appropriate funds to public health for healthpromotion, disease prevention; Schools should educate students about the importance of healthy lifestyles. (Rec. 4.1)

3. The NC General Assembly should create a study commission to identify other ways to reduce the growth in healthcare costs to lower overall costs for private and public healthcare plans.

Role and Responsibility:
Government: The NC General Assembly should fund a legislative commission to study this issue. (Rec. 4.2)

4. The NC General Assembly should enact a Healthy North Carolina program, targeted to low income, uninsured, working individuals, employers of firms with 25 or fewer employees, and selfemployed/independent contractors, which offers more affordable health insurance products than what are currently available in the North Carolina marketplace. The health insurance benefits and associated costsharing should be closely aligned with current small-group products, with the inclusion of coverage for mental health and prescription drugs.

a) Eligibility guidelines for the Healthy North Carolina program should be as follows:

i) Employer eligibility is limited to employers with 25 or fewer employees that have not provided group coverage for employees within the last 12 months. At least 30% of the employees must be

low income (defined as having an hourly wage of $12 or less, indexed annually by the Medical Component of the Consumer Price Index). To qualify, at least 75% of the eligible employees who do not have other health insurance coverage must elect coverage under this plan. Qualified employers must contribute at least 50% of the premium cost for individual coverage. Qualified employers should receive an additional tax credit to help subsidize some of the premium costs paid in excess of 50% of the premium costs for the individual if: the employer contributes more than 50% of the premium cost for individual coverage, the employer contributes toward the cost of dependent coverage, or the employer has greater than a 75% participation rate among employees who do not have other coverage.

ii) **Eligibility for self-employed individuals and independent contractors is limited to those who reside in North Carolina, are low income with family incomes equal to or less than 250% of the federal poverty guidelines, are not currently insured and have not been for the past 12 months, are not eligible for employer-sponsored group coverage, and are not eligible for Medicare.**

iii) **Individual eligibility is limited to low-income, uninsured individuals with incomes equal to or less than 250% of the federal poverty guidelines who reside in North Carolina, are employed at the time of enrollment and have been employed for a minimum of 90 days in the preceding 12 months, have no group coverage and are not eligible for employer-sponsored group coverage, were not insured within the last 12 months, and are not eligible for Medicare.**

b) **The NC General Assembly should appropriate sufficient ongoing funds to pay the reinsurance for products offered through Healthy North Carolina and to pay for additional tax credits for employers who contribute more than 50% of the premium cost for eligible employees or toward dependent coverage, or if the employer has greater than a 75% participation rate among employees who do not have other coverage.**

i) **The reinsurance corridor should be set at a level that will result in 30% lower premiums within the Healthy North Carolina program compared to comparable coverage in the private market. Actuarial analysis should be conducted to determine the appropriate reinsurance corridor for meeting the goals of the Healthy North Carolina program.**

ii) **The Healthy North Carolina program should be authorized to use program funds separately or in concert with the private industry agent community to conduct outreach and education to inform the public about the availability of the new program.**

iii) **The administrators of the Healthy North Carolina program should be authorized to use program funds to pay for evaluations of the program, to include, but not be limited to: program enrollment, the relationship between premium levels and program enrollment, program cost experience, and eligibility criteria. The evaluation should also make use of surveys of covered members, participating insurers and qualifying small employers, individuals, and self-employed individuals. The findings shall be reported to the NC**

General Assembly on a routine basis, along with any recommendations for programmatic changes.

c) The insurers should market the program and encourage brokers and others to sell the Healthy North Carolina product by offering competitive commissions.

Estimated uninsured covered: 33,500

Role and Responsibility:

Families: Uninsured individuals should purchase insurance and pay premiums (cost estimate: $79 million in premium costs for employees, self-employed, and working individuals). [a] See methodology explanation at the end of the table.
Business: Small employers should offer insurance and pay part of the premium (cost estimate: $39 million).[a]
Insurance: Insurance companies should participate in Healthy North Carolina. Agents should actively market this product to eligible small employers, sole proprietors, and working individuals.
Government: The NC General Assembly should provide financing for reinsurance and tax credits (cost estimate: $51 million for reinsurance. Does not include additional costs for tax credit).[a] (Rec. 5.1)

5. The NC General Assembly should authorize and fund a study, to be conducted by the NC Department of Insurance, of the impact of small-group reform in North Carolina and potential reforms to the existing small-group reform laws that may increase healthcare coverage among small employer groups.
   a) The study shall consider whether changes to any element of North Carolina's current small-group rating system, to the definition of small employers, or to how rating requirements apply to small employers of different sizes could be expected to result in increased coverage among small employers. In evaluating these questions, the experiences of other states' small-group rating systems should be considered.
   b) The NC Department of Insurance should convene a group that includes representatives of small business, brokers, underwriters, and other experts who can review the data and determine whether changes are needed to existing small-group reform laws.
   c) Funding for this study would enable the Department to secure data and expertise from consultants that otherwise would not be available to the Agency.

   Role and Responsibility:
   Business: Small employers should participate in the study.
   Insurance: Insurers and agents should participate in the study.
   Government: The NC Department of Insurance should convene a group to study small group reform laws. The NC General Assembly should appropriate funding for the study. (Rec. 5.2)

6. a) The NC Institute of Medicine Covering the Uninsured Task Force supports the work of the NC Health Insurance Innovations Commission, whose statutory mandate is to investigate the problems small employers face when trying to

purchase health insurance coverage and to initiate regional demonstration projects to pilot innovative health plans.

b) The NC General Assembly should appropriate funds to support the work of the Health Insurance Innovations Commission.

Role and Responsibility:

Business: Small employers should participate in the Commission.
Insurance: Insurers and agents should participate in the Commission.
Government: The NC General Assembly should appropriate funding to support the Commission. (Rec. 5.3)

7. Private insurance companies should develop and sell tiered benefit packages that offer low-cost health insurance products in North Carolina. The lowest-cost tier should offer basic healthcare coverage, which can be enhanced to include more comprehensive benefits with reduced cost sharing and higher premiums.

Estimated uninsured covered: 27,500

Role and Responsibility:

Families: Families should purchase coverage if affordable coverage is available (estimated cost: $35million in premiums. Does not include other out-of-pocket costs, including deductibles or other cost sharing).[b] See methodology explanation at the end of the table.
Business: Employers should offer and help subsidize the premium costs for their employees (estimated costs: $37 million).[b]
Insurance: Insurers should create tiered benefit products. Agents should actively market these products. (Rec. 5.4)

8. The NC General Assembly should provide the NC Department of Insurance authority and guidelines to apply state-mandated benefit laws in a flexible manner in instances where strict application of such laws would preclude the approval of tiered health insurance benefit plans, or it should enact a law regarding the application of mandated benefits that would have a similar effect.

Role and Responsibility:

Government: The NC General Assembly should amend existing state mandate laws for tiered benefit products. The NC Department of Insurance should administer the law. (Rec. 5.5)

9. The NC Division of Medical Assistance (DMA) should increase outreach and further simplify the Medicaid application and recertification process to encourage those who are currently eligible to apply and maintain their eligibility. DMA should consider, but not be limited to, the following:

a) Increasing the number of outstationed eligibility workers.
b) Streamlining the recertification process.
Estimated new eligibles: 25,500
c) See methodology explanation at the end of the table.

Role and Responsibility:

Government: The Division of Medical Assistance should further work to simplify the application process and do more outreach to encourage eligible

individuals to apply for and maintain coverage. [c] (Estimated costs based on 10% of potential eligibles enrolling. State costs: $29.2 million, county costs: $5.2 million, federal costs: $59.5 million) (Rec. 6.1)

10. The NC General Assembly should enact legislation to reduce administrative barriers and increase processing efficiency, including:
    a) Eliminating the asset (resource) test for low-income parents.
    b) Expanding the eligibility certification period from six months to 12 months.

New eligibles included in estimates for 6.1.

Role and Responsibility:

Government: The NC General Assembly should amend the Medicaid laws. [c] See methodology explanation at the end of the table. (Rec. 6.2)

11. The NC General Assembly should expand Medicaid to cover more uninsured low-income people. First priority should be to cover parents and pregnant women with incomes below 200% of the federal poverty guidelines (FPG) with a limited benefits package.

a) The NC General Assembly should direct the NC Division of Medical Assistance to seek a 1115 waiver to develop a limited benefit package. As part of the 1115 waiver, the NC General Assembly should:

i) Charge a sliding-fee scale premium that is based on the family's income, ranging from 0.5% for individuals with incomes equal to 100% of the federal poverty guidelines to 2% for individuals with incomes at 200% of the federal poverty guidelines. Nonsmokers or individuals who are actively participating in smoking cessation programs would be entitled to a 10% reduction on their premiums.

ii) Develop a limited benefit package that focuses on primary care and provides $10,000 in coverage annually for inpatient hospitalization.

iii) Include copayments and coinsurance in the benefits package on a sliding-scale basis that encourages the use of more cost effective health interventions.

iv) Enroll participants in Community Care of North Carolina (CCNC) and provide incentives to actively participate in disease and case management.

v) Implement a voluntary premium assistance program, so that low-income individuals with access to employer-sponsored insurance can use Medicaid funds to pay for their share of the premium, if cost effective to the state.

b) The NC General Assembly should cover the county's share of the cost of expansion.

Estimated new eligibles: 78,000.

Role and Responsibility:

Families: Families should enroll, pay premiums and cost sharing, and participate in disease management. (estimated costs: $5.3 million in premium costs, $86.5 million out-of-pocket cost sharing, not including any amount in excess of the $10,000 hospital inpatient coverage). [d] See methodology explanation at the end of the table.

Providers: Providers will accept Medicaid rates, which are lower than commercial rates; some of the $86.5 million in cost sharing will be absorbed by providers. [d]
Government: The NC General Assembly will appropriate funds to cover state and county share of Medicaid expansion. The NC Division of Medical Assistance should seek a waiver from the US Centers for Medicare and Medicaid Services to offer a limited benefit package. (estimated costs: $100 million in state/county costs, $170.2 million federal). [d] (Rec. 6.3)

12. The NC Division of Medical Assistance should pilot the use of an individual health risk assessment (HRA) and follow-up coaching and counseling with individual recipients in one or more of the Community Care of North Carolina (CCNC) networks to:
    a) Determine the health risks of the Medicaid population.
    b) Identify priorities for wellness initiatives.
    c) Assess the costs of implementing a HRA program statewide or with targeted eligibility groups.
    d) Assess the potential cost savings from targeted wellness initiatives.

    Role and Responsibility:
    Families: Individual enrollees will participate in wellness initiatives.
    Providers: Providers will participate in wellness initiative as part of CCNC network.
    Government: Division of Medical Assistance will develop and administer the wellness initiative through CCNC. (Rec. 6.4)

13. The NC General Assembly should enact legislation to implement a high-risk pool.
    a) Eligibility for the high-risk pool should be limited to individuals who:
        i) Are ineligible for Medicaid, Medicare, or COBRA coverage, and
        ii) Are unable to purchase a policy except with a premium that is higher than that offered through the pool or have been rejected by a commercial insurer due to pre-existing health problems.
    b) Individuals who enroll in the high-risk pool shall be subject to a pre-existing condition exclusionary period of up to 12 months unless the individual had creditable prior coverage, in accordance with NCGS §58-68-20(c) .
        i) The NC General Assembly should create an open-enrollment period of six months when the program first becomes operational to allow individuals to enroll in the program with a reduced pre-existing condition exclusionary period of six months.
    c) Premiums should be limited to 150% of the standard risk rate.
        i) The state should provide an additional subsidy to help individuals with incomes below 300% of the federal poverty guidelines pay for their share of the premium. The state subsidy would pay for 95% of the premium costs for individuals with incomes below 100% of the federal poverty guidelines to be phased out when a family's income reaches 300% of the federal poverty guidelines. The subsidy would be based on the lowest cost plan offered through the high-risk pool. Individuals who are eligible for a federal premium subsidy under the

Trade Adjustment Act must apply for such coverage. The amount of the state subsidy will be reduced by any federal premium subsidy provided.

ii) Nonsmokers or individuals who are actively participating in a smoking cessation program should be offered a discount off their premium.

iii) The high-risk pool administrator should study additional ways to encourage healthy behaviors and report back to the NC General Assembly about options within one year of program operation.

d) The high-risk pool should offer participants the choice of different insurance products, including Preferred Provider Organizations (PPOs) with different levels of deductibles and cost sharing and at least one choice of a Health Savings Account (HSA).

e) The health insurance products offered through the high-risk pool should each include no less than a $1 million lifetime limit and a sliding-scale annual limit on out-of-pocket expenses of $2,000-$5,000, based on family income. These limits should be adjusted at least once every five years to reflect changes in the medical component of the Consumer Price Index.

f) The health insurance products should include disease and/or case management to help individuals with chronic and/or complex health problems manage their health conditions.

g) The high-risk pool should also be available as a guaranteed-issue policy for HIPAA-eligible individuals in the nongroup market, and to individuals who have lost health insurance coverage as a result of the Trade Adjustment Act.

h) The costs of the high-risk pool should be financed through:

i) Premiums and other cost sharing for covered individuals.

ii) State appropriations to help pay the premium subsidy for individuals with incomes below 300% of the federal poverty guidelines.

iii) An assessment on covered lives on all health insurers, reinsurers, Multiple Employer Welfare Arrangements (MEWAs), Third Party Administrators (TPAs), Administrative Service Organizations (ASOs).

iv) Provider reimbursement limited to the Medicare reimbursement rates.

i) North Carolina should seek federal grant funds, if available, to help support the implementation and ongoing costs of operating a high-risk pool.

Estimated new eligibles: assumes 20% of medically uninsurable or 18,000 people will enroll with additional premium subsidies [e]

Role and Responsibility:

Families: People with pre-existing conditions should enroll and pay premiums and other out-of-pocket costs. (estimated costs: $32.4 million in premiums (assuming 9,000 enrollees and no additional premium subsidy. The costs to the families do not include other out-of-pocket costs, including deductible, copayments, or coinsurance). If an additional premium subsidy were provided, we assume 18,000 enrollees. Families would pay $31.6 million in premium costs (not

including other out-of-pocket costs). The state would pay the additional premium costs).[e] See methodology explanation at the end of the table.
Providers: Providers should accept Medicare rates in lieu of regular commercial rates. [estimated costs: $10 million (assuming 9,000 enrollees) or $20 million (assuming 18,000 enrollees)]. [e]
Insurance: Insurers will be assessed to create a high-risk pool [estimated costs: $30 million (assuming 9,000 enrollees) or $60 million (assuming 18,000 enrollees)]. [e]
Government: The state government would pay $33.2 million to help subsidize the premium costs for lower-income individuals with pre-existing conditions. [e] (Rec. 6.5)

[a] Estimates prepared by Mark Holmes, PhD. Vice President NC Institute of Medicine. Senior Research Fellow, Cecil G. Sheps Center for Health Services Research. Assumes: National 2003 MEPS estimates are used to derive the estimated number of individuals working in a firm that does not currently offer health insurance in "low-wage" firms, with Current Population Survey (CPS) analysis used to modify the MEPS "low-wage" firm definition to the definition used in Recommendation 5.1. A 30% premium reduction is assumed, along with the elasticity of demand obtained by Gruber and Lettau.[5] This generates the estimated number of employees in a firm that newly offers health insurance. We assume 60% eligibility and 70% take-up rates, consistent with current MEPS estimates. We then trend premium estimates forward four years from 2003 to 2007. We assume the employee share of the post-subsidized premium is 50% ($147.13 in 2007). Working and self-employed individuals are estimated using CPS for baseline enrollments. Demand elasticity of -.081 is obtained from "The Price Sensitivity of Demand for Nongroup Health Insurance," Congressional Budget Office, August 2005, Table 6.[6]

[b] The estimates are based on the assumption that 5% of the full-time uninsured workers would enroll, or 27,550 uninsured individuals. The Task Force estimated a low take-up rate because historically, limited benefit packages have not sold well in the market.[7] The estimates assume that about one third of the new enrollees would purchase Tier 1, Tier 2, and Tier 3. The cost estimates are based on monthly plan costs of $150 (Tier 1), $232 (Tier 2), and $270 (Tier 3), which were estimates provided by Mercer Government Consulting for a sample 3-tier benefit design. The costs assume that the employer would pay 75% of the lowest cost plan.

[c] The NC Division of Medical Assistance provided FY 2006 estimates per eligible. The October 2005 actual costs per eligible were: $197.31 for infants and children, $505.03 for parents of dependent children, $920.26 for pregnant women, and $1,272.53 for people with disabilities. The Task Force was unable to identify any data to know how many people who are currently eligible but not enrolled would apply for Medicaid and enroll if more outreach and program simplifications were implemented. The cost estimates included here are built around the assumption that 10% of the estimated numbers of people eligible but not enrolled would enroll. Analysis of 2001-2003 CPS data suggest that as many as 192,000 children, 46,000 parents of dependent children, 13,000 pregnant women, and 4,000 people with disabilities may currently qualify for Medicaid, but are not enrolled. This is probably an overestimate of potential eligibles, as the CPS data historically undercount the number of people enrolled in Medicaid and

does not include information to determine resource eligibility. Holmes M. Presentation to NC IOM Covering Uninsured Task Force: Cary, NC. Apr. 2005.

[d] Mercer Government Human Services Consulting. The cost estimates were based on expanding Medicaid with a limited benefit package to parents up to 200% of the federal poverty guidelines (FPG). It did not include the costs of covering first-time pregnant women with incomes between 185-200% FPG, as this recommendation was included later in the Task Force's deliberations. The estimates assume a 30% take-up rate among those potentially eligible for the limited benefit package. The estimates were adjusted for pent-up demand, antiselection factors, potential health status of participants, and benefit package design. Cost estimates are trended forward to CY 2006. Estimates do not include state or county administrative costs. The Task Force recognizes that some of the out-of-pocket costs will be paid by the families and some will be absorbed by the providers as uncompensated care.

[e] BlueCross BlueShield of North Carolina (BCBSNC) estimated that the high-risk pool would cover approximately 18,000 people (approximately 20% of medically uninsurable), with losses to the pool of roughly $40 million in addition to premiums paid (of $32.4 million) This estimate was based on BCBSNC data and experience, assuming a risk profile that resembled Blue Advantage applicants, healthcare utilization similar to those who are currently enrolled in Blue Advantage, and an administrative cost to run the pool of 7.5% of claims. The estimate assumes the Blue Advantage benefit design, which is roughly equivalent to a $1,500 deductible, $25 copay, and 75% coinsurance, and BCBSNC's Preferred Provider Organization (PPO) provider reimbursement rates. Reducing provider reimbursement in the high-risk pool to Medicare rates would provide additional savings of approximately 15%, so the total losses to the pool would be $30 million. If an additional premium subsidy were provided and 18,000 people enrolled, the losses to the pool would equal $60 million.[8] Experience from other states suggests that enrollment could be higher (between 10-30%) if the state provides an additional subsidy to help reduce the premium costs. The Task Force assumed 20% participation if the state further helped subsidize the premiums. The state subsidy estimates assume 18,000 enrollees. The percent of the state high-risk pool enrollees in each poverty category are estimated by the distribution of uninsured who specify their health as fair or poor in CPS 2003-2004. Then a sliding-scale premium subsidy was applied based on the family's income. Fourteen percent of those in fair or poor health had incomes below 100% FPG (95% subsidy), 39% had incomes between 100-200% FPG (75% subsidy), 35% had incomes between 200-300% FPG (25% subsidy), and 12% had incomes in excess of 12% (0% subsidy). If an additional premium were provided similar to these given assumptions, the enrollees would pay approximately $31.6 million, and the state would pay approximately $33.2 million.

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APPENDIX VI. NORTH CAROLINA GENERAL ASSEMBLY ACTIVITY ON RECOMMENDATIONS FROM NCIOM COVERING THE UNINSURED TASK FORCE

RECOMMENDATION 1.1: SUPPORT SAFETY NET

Appropriations Bill

The Appropriations bill (S1741) included $5 million for federally qualified health centers, state-designated rural health centers, free clinics, public health departments, and other nonprofit organizations that provide primary and preventive medical services to uninsured or medically indigent patients. This is greater than the $2 million appropriation for 2005-2006.

Studies Act Of 2006 (H1723)

The Studies Act of 2006 continued the Joint Legislative Oversight Commission on Health. One of the areas which the Joint Legislative Oversight Commission may study is:

Section 3.5. Community Health Centers (Kerr) – The Committee may study the need for community health centers, including federally qualified health centers, health centers that meet the criteria for federally qualified health centers, and State-designated rural health centers and public health departments. The Committee shall also study the need for and funding of free clinics, such as W.A.T.C.H. in North Carolina. In conducting the study, the Committee shall examine a range of approaches in depth, including, but not limited to, the following:

(1) Increasing access to preventative and primary care services by uninsured or medically indigent patients in existing or new health center locations.
(2) Establishing community health center services in counties where no such services exist.
(3) Creating new services or augmenting existing services provided to uninsured or medically indigent patients, including primary care and preventative medical services, dental services, pharmacy, and behavioral health.
(4) Increasing capacity necessary to serve the uninsured by enhancing or replacing facilities, equipment, or technologies.

RECOMMENDATION 4.1: HEALTHY LIFESTYLE INCENTIVES

H1059 (ratified) institutes changes to the State Health Plan, including authorizing the plan to incorporate incentives for healthy lifestyles.

Section 1.(b) Incentive Programs. – For the purposes of helping Plan members to achieve and maintain a healthy lifestyle without impairing patient care, and to increase cost effectiveness in Plan coverage, the Executive Administrator and Board of Trustees may adopt programs offering incentives to Plan members to encourage changes in member behavior or lifestyle designed to improve member health and promote cost-efficiency in the Plan. Participation in one or more incentive programs is voluntary on the part of the

Plan member. Before adopting an incentive program, the Executive Administrator and Board of Trustees shall conduct an impact analysis on the proposed incentive program to determine (i) whether the program is likely to result in significant member satisfaction, (ii) that it will not adversely affect quality of care, and (iii) whether it is likely to result in significant cost savings to the Plan. The impact analysis may be conducted by a committee of the Plan, in conjunction with the Plan's consulting actuary, provided that the Plan's medical director participates in the analysis. An approved incentive plan may provide for a waiver of deductibles, co-payments, and coinsurance required under this Article in order to determine the effectiveness of the incentive program in promoting healthy lifestyles for members and increasing cost-effectiveness to the Plan. The Executive Administrator and Board of Trustees shall, before implementing incentive programs authorized under this section, submit the proposed programs to the Committee on Employee Hospital and Medical Benefits for review.

RECOMMENDATION 6.5: HIGH RISK POOL
H1895 and S1681

The current version of the bill is similar to the recommendation from the Task Force It passed the House, but there was insufficient time to consider it in the Senate.

H1723, The Studies Act of 2006 (ratified) authorizes the legislative research commission to study high risk pools. (Note: The LRC may, but is not required, to study high risk pools.) In addition, the Joint Legislative Commission on Health Insurance Accessibility may also study high risk pools (see below).

RECOMMENDATION 5.1: HEALTHY NORTH CAROLINA

S1965

Senator Kerr introduced a Healthy North Carolina bill in 2005; this bill incorporates many of the recommendations by the Task Force. The bill was referred to the Committee on Appropriations/Base Budget but was not acted upon. The concept was too new, and the Senate needed to hire an actuary to develop cost estimates for the bill. Unfortunately, the General Assembly didn't have enough time in the short session to fully explore the legislation.

Appropriations Bill

However, the General Assembly did enact a small tax credit, targeted at small employers, to help encourage them to provide health insurance. The appropriations bill states:

Small Business Health Insurance Tax credit

Section 24.4.(a) Article 3B of Chapter 105 of the General Statutes is amended by adding a new section to read:

"**§ 105-129.16E. Credit for small business employee health benefits.**

(a) Credit. – A small business that provides health benefits for all of its eligible employees during the taxable year is allowed a credit to offset its costs in providing health benefits for its eligible employees. For the purposes of this subsection, a taxpayer provides health benefits if it pays at least fifty percent (50%) of the premiums for health care coverage that equals or exceeds the minimum provisions of the basic health care plan of coverage recommended by the Small Employer Carrier Committee pursuant to G.S. 58-50-125 or if its employees have qualifying existing coverage.

The credit is equal to a dollar amount per eligible employee whose total wages or salary received from the business does not exceed forty thousand dollars ($40,000) on an annual basis. The dollar amount is two hundred fifty dollars ($250.00), not to exceed the taxpayer's costs of providing health benefits for the employee during the taxable year.

(b) Allocation. – If the taxpayer is an individual who is a nonresident or a part-year resident, the taxpayer must reduce the amount of the credit by multiplying it by the fraction calculated under G.S. 105-134.5(b) or (c), as appropriate. If the taxpayer is not an individual and is required to apportion its multistate business income to this State, the taxpayer must reduce the amount of the credit by multiplying it by the apportionment fraction used to apportion its business income to this State.

(c) Definitions. – The following definitions apply in this section:
(1) Eligible employee. – Defined in G.S. 58-50-110.
(2) Qualifying existing coverage. – Defined in G.S. 58-50-130(a)(4a).
(3) Small business. – A taxpayer that employs no more than 25 eligible employees throughout the taxable year.

(d) Sunset. – This section expires for taxable years beginning on or after January 1, 2009."

Section 24.4.(b) This section is effective for taxable years beginning on or after January 1, 2007.

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Studies Act

The Studies Act of 2006 created a Joint Legislative Commission on Health Insurance Accessibility (Section 20 of H1723). This Commission is directed to study the feasibility of creating a Healthy New York or similar program in North Carolina.

Studies Act of 2006 (H1723). Joint Legislative Commission on Health Insurance Accessibility

Section 20.1. There is established in the General Assembly a Joint Legislative Commission on Health Insurance Accessibility.

Section 20.2. Membership. – The Commission shall be composed of 16 members as follows:

(1) Eight members of the House of Representatives appointed by the Speaker of the House of Representatives.
(2) Eight members of the Senate appointed by the President Pro Tempore of the Senate.

Vacancies on the Commission shall be filled by the appointing authority. Cochairs of the Commission shall be designated by the Speaker of the House of Representatives and the President Pro Tempore of the Senate from among their respective appointees. The Commission shall meet upon the call of the cochairs.

Section 20.3. The Commission shall study the legal, fiscal, and policy implications of various means of increasing accessibility to health insurance. The Commission may study the creation of a North Carolina Health Insurance Risk Pool (H.B. 1535 – Insko, Holliman) and a North Carolina Fair Share Health Insurance Access Program (H.B. 2860 – Holliman).

The study shall specifically address strategies for increasing accessibility to health insurance by small employer groups, self-employed individuals, and individuals who are employed but uninsured. The study of small employer access shall include the following:

(1) A review of the number of small employers (50 or fewer employees) in this State, grouped by industry and volume of business; the number of small employers that offer comprehensive health insurance coverage to their employees; and the average premium charged for comprehensive health insurance coverage available to small employer groups in this State, as compared to premiums for comparable coverage in the Southeast region and other areas of the United States.
(2) A review of the participation rates, premiums and cost-sharing, and coverage options offered under the North Carolina Small Employer Group Health Coverage Reform Act, Part 5, Article 50 of Chapter 58 of the General Statutes.
(3) An analysis of the Healthy New York Program administered by the State of New York, or similar program, that combines the provision of a standardized, streamlined benefit package with state-funded reinsurance in the form of a stop-loss fund that would reimburse insurers for the costs of claims within a defined claims corridor. In conducting the analysis the Commission shall review and consider the proposed committee substitute for Senate Bill 255, 2005 Regular Session of the General Assembly. The analysis shall also review the amount in state funds appropriated for the Healthy New York Program since its inception, and corresponding participation rates by employers and eligible individuals.
(4) An analysis of providing additional tax benefits for small businesses that provide health insurance coverage for their employees.

Section 20.4. Members of the Commission shall receive per diem, subsistence, and travel allowances in accordance with G.S. 120-3.1, 138-5, or 138-6, as appropriate. The Legislative Services Office shall provide adequate staff for the Commission. The Commission may hire consultants to assist with the study as provided in G.S. 120-32.02(b). The Commission, while in the discharge of its official duties, may exercise all the powers provided under the provisions of G.S. 120-19 and G.S. 120-19.1 through G.S. 120-19.4, including the power to request all officers, agents, agencies, and departments of the State to provide any information, data, or documents within their possession, ascertainable from their records, or otherwise available to them and the power to subpoena witnesses. The Commission may meet during a regular or extra session of the General Assembly, subject to approval of the Speaker of the House of Representatives and the President Pro Tempore of the Senate.

Section 20.5. The Commission shall make a final report of its findings and recommendations to the 2007 General Assembly. The interim report may and the final report shall include findings and recommendations on:

(1) Whether the State should provide for the implementation of a small employer health insurance program that is supported with State funds to ensure comprehensive coverage and affordability for small employer groups, self-employed individuals, and employed but uninsured individuals. If the Commission recommends implementation, the recommendation should specifically address strategies for avoiding adverse selection and crowd-out, eligibility factors such as family income, limitations on claims thresholds and corridors for stop-loss coverage, benefit levels and limitations, and the feasibility and advisability of establishing a State high-risk pool.
(2) An estimate of the cost to the State to support stop-loss coverage, high-risk coverage, or other approaches to ensuring small employer health insurance access and affordability.
(3) Other findings and recommendations relevant to the purposes of the study.

The Commission shall terminate upon the filing of its final report or the adjournment of the 2007 General Assembly.

Section 20.6. Of the funds appropriated to the General Assembly, the Legislative Services Commission shall allocate funds for the expenses of the Commission established by this part.

RECOMMENDATION 5.2: REVIEW SMALL GROUP RATING

Recommendation 5.2 was for the Department of Insurance to study changes to small group rating laws. H1987 was ratified and implemented the changes recommended by the workgroup.

RECOMMENDATION 6.3: LIMITED BENEFIT MEDICAID EXPANSION

Although there was no consideration of Medicaid expansion *per* se, Section 10.12 of the Senate Appropriations Bill (S1741) includes a provision directing DHHS to study ways to increase health care access for uninsured persons. While this does not directly follow the Task Force Medicaid recommendation, it directs the Department to study the possibility of a Medicaid waiver to expand coverage to more uninsured.

Increase Health Care Access for Uninsured Persons

Section 10.12.(a) The Secretary of the Department of Health and Human Services shall develop a plan to expand health care access for uninsured North Carolinians through the use of public/private partnerships, federal flexibility and resources, and promotion of charity care by health care providers. The goals of the plan are to:

(1) Aid small businesses that want to provide health care coverage.
(2) Expand health care coverage for the working uninsured persons.
(3) Secure all available federal funds to support the program.
(4) Promote charity care by health care providers.

Section 10.12.(b) In developing the plan, the Secretary shall:

(1) Consider findings and recommendations of previous studies on increased access to health care and covering the uninsured to determine their feasibility.
(2) Draw on the experience of other states that have successfully increased access to health care and covered the uninsured.
(3) Determine waivers necessary to secure federal funding available through 1115 Demonstration Waivers and other federal waivers to cover the uninsured.
(4) Explore options such as those available through the Deficit Reduction Act of 2005 (DEFRA) to adjust Medicaid eligibility and benefits to cover the uninsured.
(5) Consider the use of existing funding that might be used to leverage additional federal matching funds including certified public expenditures (CPE), and appropriate federal Disproportionate Share Hospital Program (DSH) funds.
(6) Pursue an agreement with the Centers for Medicare and Medicaid Services (CMS) to develop a methodology for investing Medicare savings realized from the expansion of the scope of Community Care of North Carolina Program to help fund the plan; and
(7) Determine in conjunction with the Office of State Budget and Management the fiscal impact of the plan for a five-year period.

Section 10.12.(c) Of the funds appropriated in this act to the Department of Health and Human Services, Division of Medical Assistance, the sum of one hundred thousand dollars ($100,000) for the 2006-2007 fiscal year shall be used to support the development of the plan. The proposed plan shall be submitted to the 2007 General Assembly not later than March 1, 2007.

APPENDIX VII: RECOMMENDATIONS OF THE NC IOM HEALTH CARE SAFETY-NET TASK FORCE (PRIORITY RECOMMENDATIONS ARE LISTED IN BOLD)

1. **The North Carolina General Assembly should take steps to make health insurance coverage more affordable and to expand health insurance coverage to more uninsured individuals. (Rec. 2.1)**

2. The Office of the Secretary of the NC Department of Health and Human Services should continue its efforts to monitor access to behavioral health services for the uninsured and other underserved populations. The Office of the Secretary should examine access to services for both the priority (target) populations and for those with less severe behavioral health problems and should seek input from a wide variety of stakeholders including, but not limited to, publicly funded local management entities, children's development services agencies, behavioral health providers, primary care providers, safety net organizations, and representatives of consumer groups. (Rec. 3.1)

3. The Office of the Secretary should work with the NC Pediatric Society, NC Academy of Family Physicians, NC Chapter of the American College of Physicians, NC Psychiatric Association, other interested professional associations, and NC Area Health Education Centers program to examine ways to expand the capacity of primary care providers to address some of the behavioral health needs of the uninsured and/or underserved populations. Information on this initiative should be reported to the NC Commission for Mental Health, Developmental Disabilities and Substance Abuse Services. (Rec. 3.2)

4. **The NC Office of Research Demonstrations and Rural Health Development (ORDRHD), in collaboration with the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill, should assume responsibility for collecting data and monitoring the capacity of the safety net on an ongoing basis.**
   - **a) The data should include information on safety net organizations that provide the full array of primary care services, as well as those that provide dental, behavioral health, preventive services only, or a less comprehensive array of clinical services. In addition, data should be collected on the numbers uninsured who receive services through non-profit or public dental clinics, pharmacy clinics, or other specialty providers.**
   - **b) Safety net healthcare organizations that receive state funding (through Medicaid, the Division of Public Health, or Community Health Grant funds) should be required to report information to the ORDRHD on the unduplicated number of and the total number of visits (encounters) for uninsured patients who receive comprehensive primary care, dental, behavioral health, or other clinical services. The ORDRHD should create a standardized reporting form to ensure that the data are collected consistently across healthcare organizations. Other organizations that do not receive any state funding, such as free clinics, should be encouraged to provide similar information.**
   - c) **The ORDRHD should share these data with local Community Care of North Carolina groups, Healthy Carolinian organizations, local health departments, the NC Association of Community Health Centers, the NC Hospital Association, the North Carolina Medical Society, the NC Free Clinic Association, the NC Division of Facility Services, and local medical societies so that they can use these data to identify areas of unmet need. Similarly, the data should be shared**

with North Carolina health foundations, to help inform their grant making process.

d) The ORDRHD should report these data to the Secretary, Governor, General Assembly, and NC Association of County Commissioners on a yearly basis to help inform policymakers of areas of greatest unmet need. (Rec. 4.1)

5. The NC Office of Research, Demonstrations and Rural Health Development should take the lead in pulling together a statewide collaborative of safety net organizations to develop a planning package for communities interested in maintaining or expanding their safety net capacity.

a) **The collaborative should include, but not be limited to: the Division of Public Health, the NC Community Health Center Association, the NC Hospital Association, the North Carolina Medical Society, the NC Free Clinic Association, and the NC Area Health Education Centers (AHEC) program. These groups should collaborate to provide technical assistance to communities. Priority should be given to low-wealth, high-need communities to help them develop additional safety net capacity. Cross-county or regional approaches should be considered, particularly for smaller, less-populated, or resource poor communities.**

b) **The planning package should include information on financial planning, possible funding sources, healthcare information systems, record access and confidentiality, federal and state laws and regulations affecting the provision of safety net services, and the organizational aspects of interagency cooperation with such issues as eligibility determination. Once developed, information about the availability of the planning package and technical assistance should be provided to county commissioners, local healthcare providers, community collaborations (such as Healthy Carolinians and Community Care of North Carolina networks), and other interested non-profit organizations. (Rec. 4.2)**

6. The North Carolina Medical Society, local medical societies, free clinics, Project Access models, and other community initiatives that encourage private providers to donate their services to the uninsured should develop systems to recognize providers for their services. Recognition should be provided at both the local and state levels. (Rec. 4.3)

7. **The NC Free Clinic Association should take the lead in pulling together a group of health professionals and safety net organizations, including, but not limited to, the North Carolina Medical Society and NC Project Access organizations to identify options to reduce the fear of and/or threat of malpractice lawsuits against providers who volunteer their time to serve the uninsured without compensation. At a minimum, the group should examine the existing Good Samaritan law to determine if further changes are needed to provide protection to physicians and other healthcare professionals who volunteer to provide services to the uninsured upon referral from an organized system of care for low-income uninsured. (Rec. 4.4)**

8. The Office of Research, Demonstrations and Rural Health Development and other safety net organizations should create a workgroup to meet with pharmaceutical companies to discuss:

a) Simplifying and streamlining the Patient Assistance Programs, including the application forms, verification requirements, and eligibility requirements;

b) Creating bulk replenishment programs and other ways the pharmaceutical industry could help provide medications to safety net organizations.

c) Information should be disseminated to safety net organizations and private physician practices about the best way to access existing pharmaceutical resources. (Rec. 5.1)

9. The NC General Assembly should support the Health and Wellness Trust Fund's efforts to support and expand prescription assistance programs, including, but not limited to, expanding the availability of MARP and medication assistance programs. (Rec. 5.2)

10. **North Carolina private foundations should consider three-year start-up funding at $180,000/year to the NC Office of Research, Demonstrations and Rural Health Development to create a bulk medication replacement system. (Rec. 5.3)**

11. The NC Office of Research, Demonstrations and Rural Health Development should explore opportunities to expand 340B drug discount prices to low-income patients of other safety net organizations. (Rec. 5.4)

12. The NC General Assembly should enact legislation that clarifies existing state confidentiality laws to ensure that safety net providers are allowed to share identifiable health information with each other when providing care to the same patients, consistent with applicable federal law. The legislation should include heightened protections for particularly sensitive information, such as mental health and communicable disease information. (Rec. 6.1)

13. The NC Office of Research, Demonstrations and Rural Health Development should collect and disseminate descriptions of various models of collaboration and integration found to work well in particular communities. (Rec. 6.2)

14. In addition to healthcare providers, local safety net collaborations should encourage the participation of business and industry, colleges and universities, faith-based organizations, social service agencies, non-profits, and other interested groups in community collaborations to provide care to the uninsured. (Rec. 6.3)

15. **North Carolina foundations should help convene a best practices summit of safety net organizations that will focus on collaboration and integration. This summit would help local communities identify ways to build and strengthen their capacity to meet the healthcare needs of the growing uninsured population, and to reduce barriers to interagency collaboration and integration. Summit participants should include representatives of existing safety net organizations at the state and local levels. One of the outgrowths of this summit would be to develop clearer and measurable criteria of collaboration to guide future decisions for safety-net program support by public and private funding agencies. (Rec. 6.4)**

16. Hospitals should take the lead to develop collaborations with local safety net organizations to help ensure that the uninsured have appropriate medical homes and after-hours care for persons requiring non-emergent attention. (Rec. 6.5)

17. **The NC Institute of Medicine should create an on-going state-level Safety Net Advisory Council that can encourage state-level and local safety net collaborations and can help monitor the implementation of the Safety Net Task Force's recommendations. The group should include the full array of existing safety net organizations, including health departments, federally qualified health centers, free clinics, hospitals, medical societies, Project Access and Healthy Communities Access Programs, medication assistance programs, and other non-profit agencies providing**

care to the uninsured. (Rec. 6.6)

18. **The NC Department of Health and Human Services, NC Community Health Center Association, NC Association of Free Clinics, North Carolina Health Directors Association, NC Hospital Association, NC Medical Society, and other safety net organizations should work with the NC congressional delegation to support North Carolina safety net organizations.**
    - **a) The NC congressional delegation should oppose any efforts to create a Medicaid block grant or otherwise limit the availability of federal Medicaid funds to the states.**
    - **b) In order to ensure that North Carolina receives its fair share of federal funding for federally qualified health centers (FQHCs), the NC congressional delegation should work to ensure that priority for new FQHC funding should be given to states that have higher than average proportions of uninsured, racial disparities, and/or a lower than average receipt of federal FQHC funds per low-income person.**
    - c) **The NC congressional delegation should also work to ensure that North Carolina receives its fair share of federal State Children's Health Insurance Program (SCHIP) and Ryan White CARE funds, and that Congress continues funding the Special AIDS Drug Assistance Program (ADAP) Initiative.**
    - d) **The NC congressional delegation should work to expand the 340B program to include free clinics, local health departments, and other non-profit or governmental agencies with a mission to serve low-income uninsured patients. (Rec. 7.1)**

19. The NC Health Directors Association should develop a legislative proposal to amend state laws to enable local boards of public health to create governance structures that would make them eligible to participate in additional federal programs through which funding is available to support care for the uninsured. (Rec. 7.2)

20. The North Carolina health foundations should consider additional funding to meet the capital and infrastructure needs of healthcare safety net organizations. (Rec. 7.3)

21. **The NC General Assembly should appropriate, on a recurring basis, $6 million to be used for federally qualified health centers and those health centers that meet the criteria for federally qualified health centers, and $5 million to be used for state-designated rural health centers, public health departments, and other non-profit healthcare organizations with a mission to serve the uninsured and other medically underserved populations. The funds shall be used to:**
    - **a) Increase access to preventive and primary care services by uninsured or medically indigent patients in existing or new health center locations;**
    - **b) Establish health center services in counties where no such services exist;**
    - **c) Expand the Office of Research, Demonstrations and Rural Health Development's Medical Access Program (MAP) to safety net providers who currently receive no financial support for indigent care and who are located in high-needs counties;**
    - **d) Create new services or augment existing services provided to uninsured or medically indigent patients, including primary care and preventive medical services, dental services, pharmacy, and behavioral health;**
    - **e) Increase capacity necessary to serve the uninsured by enhancing or replacing facilities, equipment, or technologies; and**

f) Create or augment community collaborations or integrated delivery systems that have the capacity to expand health services to the uninsured or medically indigent patients.

Of the $5 million appropriated to state-designated rural health centers, public health departments, and other non-profit healthcare organizations, $140,000 shall be provided to the Office of Research, Demonstrations and Rural Health Development to develop planning packages for local communities interested in developing safety net programs, provide technical assistance, and collect data on the capacity of the existing safety net to meet the needs of the uninsured and medically uninsurable. (Rec. 7.4)

22. The NC General Assembly should appropriate $11.35 million in SFY 2005-2006 and $25.95 million in SFY 2006-2007 to expand the number of school health nurses with the goal of fully implementing the school health nurse initiative over the next five years. (Rec. 7.5)

23. The Division of Medical Assistance should explore different Medicaid payment rules that would provide higher reimbursement to FQHCs, FQHC look-alikes, and rural health clinics (RHCs) that serve a disproportionately high percentage of uninsured. New funds should be used to support and expand care to the uninsured. (Rec. 7.6)

24. The Division of Medical Assistance should assure that reimbursement to local health departments for Medicaid services will be at actual cost (same as for FQHCs, RHCs, and CHCs). Rates should be adjusted annually to account for the full cost to provide services or the annual cost settlement payment should include the full share (county, state, and federal) of Medicaid payments. New funds should be targeted to providing care to the uninsured (comprehensive primary care, population-based services, or other more targeted clinical services). (Rec. 7.7)

25. The NC General Assembly, NC Division of Medical Assistance, and NC State Employees Health Plan should consider options to enhance payments to hospitals that serve high proportions of uninsured patients or that meet identified health shortage needs by providing other critical health services.
    a) Options may include, but are not limited to, increasing Medicaid or other reimbursement to achieve this goal or exploring whether Disproportionate Share Hospital-related supplemental payments can be used for this purpose.
    b) The General Assembly should appropriate new funds for this purpose.
    c) In distributing new funds, the state should recognize other funds the hospitals receive to serve the uninsured.

    New funds should be targeted to expanding care to the uninsured. (Rec. 7.8)

26. The Division of Medical Assistance should explore the possibility of creating a system of "shared savings" with regional Community Care of North Carolina (CCNC) networks. Savings that are retained by regional networks should be used to provide similar health services to the uninsured. (Rec. 7.9)

27. The NC Division of Medical Assistance (DMA) should ensure that the federal Medicaid spend-down rules that allow applicants to use the value of healthcare services paid by state and county programs in meeting their spend-downs are fully implemented. In so doing, the DMA should:

a) Explore which programs are eligible for this deduction, including, but not limited to, DPH purchase of care programs, AIDS Drug Assistance Program (ADAP), mental health, and MAP programs.
b) Work with the other state agencies that administer these programs to develop cost of care statements, and, ultimately, develop systems to facilitate the exchange of information about the value of services provided across programs to simplify the spend-down process for applicants. (Rec. 7.10)

28. The Division of Medical Assistance should continue its work to simplify the Medicaid application process for parents, people with disabilities, and older adults. Specifically, the Division should:
a) Create a simplified application form
b) Extend the length of time for recertification
c) Explore the possibility of eliminating the assets test for families with children. (Rec. 7.11)

ADDITIONAL FOOTNOTES:

[i] The federal poverty guidelines are set annually by the US Department of Health and Human Services, as a means of determining eligibility for certain federal programs. They are based on the federal poverty threshold, developed by the US Census. The federal poverty guidelines vary, by size of the family. In 2005, the federal poverty guidelines are:

Family Size	2005 Federal Poverty Guidelines (FPG)
1	$ 9,570
2	$12,830
3	$16,090
4	$19,350
5	$22,610
6	$25,870
7	$29,130
8	$32,390
For each additional person	$ 3,260

Source: 2005 HHS Federal Poverty Guidelines. Available online at: http://aspe.hhs.gov/poverty/05poverty.shtml (accessed May 17, 2005).

[ii] Holmes M. County-level Estimates of the Number of Uninsured in North Carolina: 2003 Update. Cecil G. Sheps Center for Health Services Research. University of North Carolina at Chapel Hill. Available online at: http://www.shepscenter.unc.edu/publications/NorthCarolinaUninsured2003FindingsBrief.pdf (Accessed May 23, 2005).

[iii] Providers are paid $2.50 per member, per month to manage all of the patient's care (e.g., be available 24 hours-a-day, seven days-a-week, 365 days-a-year, coordinate referrals, etc.). Networks receive an additional $2.50 per member, per month. A network of providers improves care by using a team of providers to coordinate referrals at the local level, and also by becoming part of the statewide medical management team.