Overview

Approximately 20% of the 1.5 million uninsured in North Carolina in 2006-2007 were children (ages 0-18). This equates to 13% of *all* North Carolina children, or 306,000 children.[a]

Children who are uninsured are more likely to forgo needed health care than children with health insurance.[1] A national study found that only 45% of uninsured children had received a "well child" checkup, compared to 76% of children with public insurance.[2] The study also found that among children with special health care needs, nearly 41% of uninsured children had delayed or foregone care, compared to fewer than 10% of uninsured children.

Children without health insurance have less access to health care services. In 2007, about 16% of uninsured children in North Carolina did not receive all the care their parents thought they needed, compared to less than six percent of insured children. Not surprisingly, cost was the major reason uninsured children did not receive care. Uninsured children were more likely to have never seen a dentist or to have not seen one in more than two years, and less likely to have someone as a "personal" doctor or provider. Uninsured children were roughly twice as likely to delay getting medicine and half as likely to not have had a well visit. Additionally, parents of uninsured children were less likely to rate their child's health as "Excellent."[3]

The percentage of uninsured children has grown more rapidly in North Carolina than nationally. Between 2000-2001 and 2006-2007, the percentage of children who lacked health insurance coverage grew by 2.8 percentage points in North Carolina (from 10.3% to 13.1%), whereas the percentage of uninsured children nationally fell by 0.1 percentage points (from 11.5% to 11.4%). This is due primarily to a larger deterioration of employer-sponsored insurance (ESI) in North Carolina compared to the rest of the nation. (See Table 4.1.)

Between 2000-2001 and 2006-2007, the percentage of children who lacked health insurance coverage grew by 2.8 percentage points in North Carolina, whereas the percentage of uninsured children nationally fell by 0.1 percentage point.

Table 4.1
Percent of Children Lacking Health Insurance Has Grown Between 2000-2001 and 2006-2007

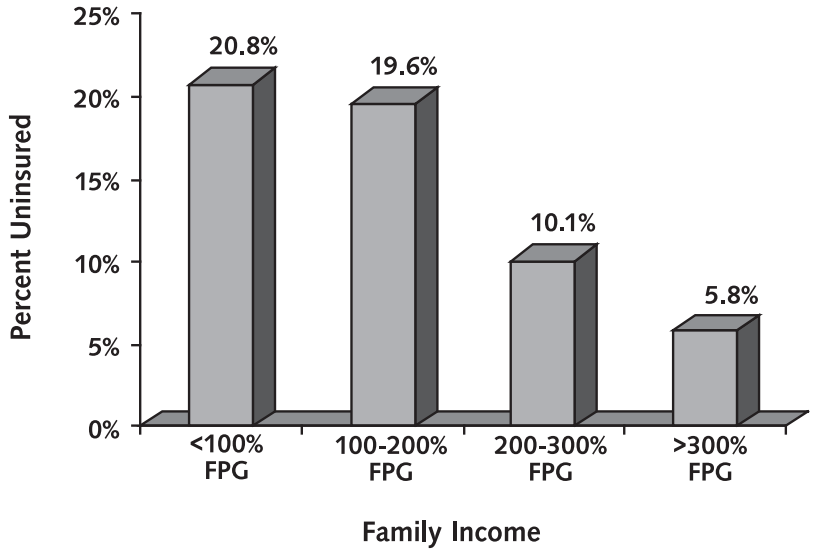
	ESI	Individual	Medicaid/ SCHIP	Uninsured
North Carolina	-10.1%	-0.4%	6.1%	2.8%
United States	-5.6%	0.3%	5.8%	-0.1%

Source: North Carolina Institute of Medicine. Analysis of the US Census Bureau, Current Population Survey's Annual Social and Economic Supplement. Table HIA-5 two-year averages, 2000-2007.

a Unless otherwise noted, all data on the uninsured are based on North Carolina Institute of Medicine analysis of the Current Population Survey's Annual Social and Economic Supplement, published by the US Census Bureau.

Poor children are the most likely to lack insurance coverage compared to other children. The percentage of children who are uninsured range from 20.8% for those with family incomes below 100% of the federal poverty guidelines (FPG) ($21,200/year for a family of four in 2008) to 5.8% for those with household incomes above 300% FPG ($63,600/year for a family of four in 2008). (See Figure 4.1.)

Figure 4.1
Children with Family Incomes Below 200% FPG are More Likely to be Uninsured



Source: North Carolina Institute of Medicine. Analysis of the US Census Bureau, Current Population Survey's Annual Social and Economic Supplement. 2006-2007.

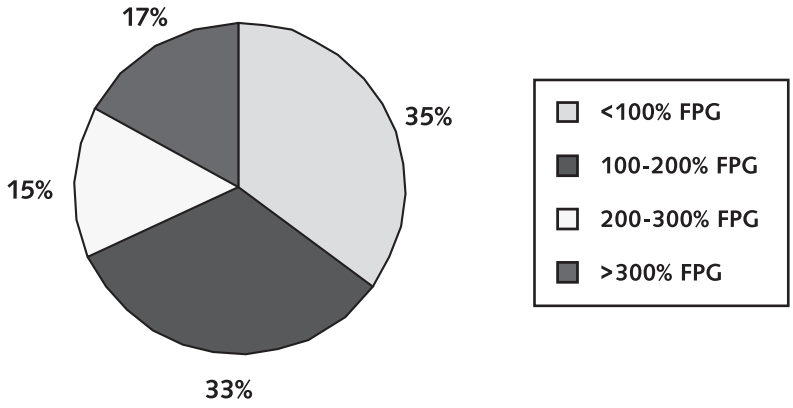
More than one-third (35%) of uninsured children have family incomes of less than 100% of the federal poverty guidelines (FPG), and another 33% of uninsured children have family incomes between 100%-200% FPG.

Not only are poor children more likely to lack health insurance, they also comprise two-thirds of all uninsured children. More than one-third (35%) of uninsured children have family incomes of less than 100% FPG, and another 33% of uninsured children have family incomes between 100%-200% FPG. In total, more than two-thirds of all uninsured children live in a family with incomes less than 200% FPG ($42,400/year for a family of four in 2008). (See Figure 4.2.)

Medicaid and NC Health Choice Program Eligibility

There are two insurance programs available to provide health insurance coverage to low-income children: Medicaid and the State Children's Health Insurance Program (SCHIP). Both are jointly administered between the federal and state governments. Typically, Medicaid is provided to lower-income children and has less cost sharing, and SCHIP is available to cover children with slightly higher

Figure 4.2
Children in Families with Incomes Below 200% FPG Make Up the Majority of Uninsured Children



Source: North Carolina Institute of Medicine. Analysis of the US Census Bureau, Current Population Survey's Annual Social and Economic Supplement. 2006-2007.

family incomes. In most cases, children must be citizens to qualify, and must have family incomes below a state established income limit.[b,c]

Medicaid is an entitlement program, which means that eligible children are guaranteed coverage. States can change the eligibility rules and/or limit benefits within certain federal parameters. However, every child who meets the established eligibility rules is entitled to coverage, regardless of the state or federal government's budgetary restrictions. Children need not be uninsured in order to qualify for Medicaid, they can have both private coverage and Medicaid. In these instances, Medicaid becomes the secondary payer, and only covers services or costs not already covered by the private insurance plan. In contrast, SCHIP is limited to uninsured children. Children cannot have both private insurance coverage and SCHIP. Another major difference is the federal funding; SCHIP is a block grant program. The federal government allocates a certain amount of money to the states. When funding runs out, children can be denied coverage or put on a waiting list.

In North Carolina, children are eligible for Medicaid or NC Health Choice (North Carolina's SCHIP program) if their household incomes are below 200% FPG and they meet the citizenship requirements. Medicaid (also referred to as Health

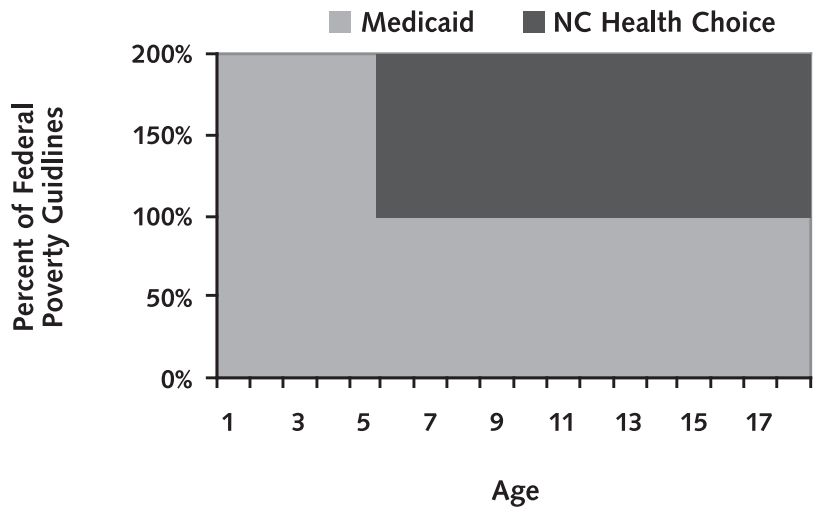
In North Carolina, children are eligible for Medicaid or NC Health Choice if their household incomes are below 200% of the federal poverty guidelines and they meet the citizenship requirements.

b Non-citizens are generally not eligible for health insurance coverage through Medicaid or the State Children's Health Insurance Program. However, there are some immigrants who can qualify. Refugees or asylees may be eligible if they have low enough incomes and otherwise meet eligibility requirements. In addition, some immigrants may qualify after they have resided in the United States lawfully for five years.

c Some states also impose resource limits (e.g. money in the bank). However, North Carolina, like 46 other states for Medicaid and 34 other states for State Children's Health Insurance Program, does not impose a resource limit for coverage for children. (Ross DC, Horn A, and Marks C; Kaiser Commission on Medicaid and the Uninsured. Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles. http://kff.org/medicaid/upload/7740_ES.pdf. Accessed January 5, 2009.)

Check) covers children from birth through age five with family incomes no greater than 200% FPG and children ages 6-18 with incomes up to 100% FPG. NC Health Choice covers children ages 6-18 with family incomes between 100%-200% FPG. (See Figure 4.3.) The North Carolina Division of Medical Assistance (DMA) administers the Medicaid program. NC Health Choice is administered jointly by DMA and the State Employees' Health Plan.

Figure 4.3
Medicaid and NC Health Choice Cover Children (0-18) with Family Incomes Below 200% FPG



Source: Division of Medical Assistance, North Carolina Department of Health and Human Services, 2008.

Over the last seven years, the North Carolina General Assembly has established growth caps for the NC Health Choice program.

In November 2008, there were 773,859 children enrolled in the North Carolina Medicaid program, and 123,892 children enrolled in NC Health Choice.[4] Over the last seven years, the North Carolina General Assembly has established growth caps for the NC Health Choice program. For example, in the 2008 Session, the North Carolina General Assembly limited enrollment growth in the NC Health Choice program to six percent. At the time, the country was waiting for SCHIP to be reauthorized.[d] The North Carolina General Assembly specified that if SCHIP was reauthorized, then NC Health Choice could grow by up to 8.73%. Historically, North Carolina limited enrollment growth because the amount of the federal SCHIP block grant allocated to North Carolina was not sufficient to cover all eligibles. In fact, North Carolina was the first state in the country to impose an

d The State Children's Health Insurance Program was scheduled to be reauthorized in 2007. Congress voted to reauthorize and expand the program to cover more eligibles. However, President Bush vetoed the legislation on two separate occasions. As a result, the State Children's Health Insurance Program legislation was extended until March 31, 2009.

enrollment freeze in their SCHIP program (2001).[5] North Carolina has maintained an open enrollment period since that time, although it made other changes in program rules to ensure that eligible children could be covered.[e]

The federal SCHIP program was recently reauthorized (early 2009) for five years.[f] The reauthorization included several important program changes.[6] First it gave states the authority to cover uninsured children with family incomes up to 300% FPG. States can cover children with higher incomes but at the lower Medicaid match rates. The reauthorization also provided additional options and incentives to improve states' enrollment and retention efforts. These include allowing states to use Express Lane Eligibility, under which information collected for other programs (such as Food Stamps) can be used when evaluating a child's eligibility for Medicaid or SCHIP. Bonus payments will also be provided to states that streamline enrollment and retention processes and increase Medicaid enrollment of children above certain target levels. In addition, Congress gave states the authority to cover pregnant women through SCHIP, and to provide Medicaid and SCHIP to legal immigrant children and pregnant women. (Previously, legal immigrants were barred from receiving coverage for five years from their date of entry even if they otherwise met the eligibility requirements.) The reauthorization is expected to increase North Carolina's 2009 federal SCHIP allotment by an estimated $90 million (from $136 million to $246 million).[g,7] Congress funded this reauthorization by increasing the federal tobacco tax by 61.66 cents per pack.

Approximately three out of every five uninsured children in North Carolina (186,000 children) are currently eligible for, but not enrolled in, Medicaid or NC Health Choice.

Outreach and Enrollment Simplification

Approximately three out of every five uninsured children in North Carolina (186,000 children) are currently eligible for, but not enrolled in, Medicaid or NC Health Choice. That is, they are citizen children who live in a household with a family income no greater than 200% FPG. Another 23,000 are not eligible because of citizenship status,[h] and 97,000 are not eligible because their family incomes are above 200% FPG. (See Figure 4.4.) This is not a problem unique to North Carolina. However, other states have implemented successful outreach and administrative simplification strategies to try to identify, enroll, and retain eligible children.

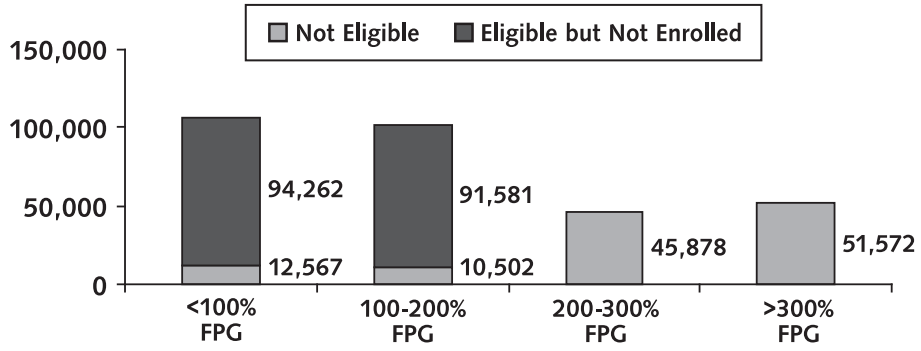
e In 2005, the North Carolina General Assembly changed coverage for the youngest children. Previously, children birth through age one were eligible for Medicaid if their family incomes was no greater than 185% FPG, and children ages one through age five were eligible if their family incomes was no greater than 133% FPG. Children birth through age five in families with higher family incomes (but no greater than 200% FPG) were eligible for NC Health Choice. Effective January 1, 2006, children birth through age five were moved to Medicaid (an entitlement program) if their family income did not exceed 200% FPG. The eligibility rules did not change for older children. Thus, children ages six through 18 are eligible for Medicaid (an entitlement program) if their income is no greater than 100% FPG, and if their family income is higher, then they may qualify for NC Health Choice.

f Pub L No.111-003

g 41 states, including North Carolina, plus the District of Columbia, were expected to have significant State Children's Health Insurance Program funding shortfalls in FY2009 if Congress maintained its funding formula. (McNichol E, Lav IJ; Center of Budget and Policy Priorities. State budget troubles worsen. http://www.cbpp.org/9-8-08sfp.htm. Accessed November 26, 2008.)

h The data used to estimate the number of eligible children does not distinguish between immigrants who are here lawfully (and who may qualify after five years), and those who are in North Carolina without appropriate documents. Therefore, the North Carolina Institute of Medicine only counted uninsured *citizen* children in the estimates of children who are already potentially eligible for Medicaid or NC Health Choice.

Figure 4.4
Children Eligible for but not Enrolled in Medicaid or NC Health Choice



Source: North Carolina Institute of Medicine. Analysis of the US Census Bureau, Current Population Survey's Annual Social and Economic Supplement, 2006-2007.

County Departments of Social Services (DSS) are required to determine eligibility during both the initial application and during annual recertification.

County Departments of Social Services (DSS) are required to determine eligibility during both the initial application and during annual recertifications. Applications are available through county DSSs, health departments, and through many health care providers or community organizations. Applications can also be downloaded off the web or requested over the phone. Many community organizations and health care providers help families complete their application; however, the applications must be sent to the county DSS to be processed. County DSS eligibility workers will follow-up with the individual if the application is missing information. For example, federal law requires that every Medicaid and/or SCHIP enrollee verify citizenship if they are not eligible as a qualified legal immigrant. States can require families to provide other verifications in addition to that required by the federal government. North Carolina requires that all families submit verification of earned income by submitting wage stubs or other verification for the month prior to application. Children eligible for NC Health Choice must also pay a yearly enrollment fee ($50 for one child or $100 for two or more children) before becoming eligible (or being recertified).

The state Division of Medical Assistance (DMA) sends a reenrollment (recertification) reminder postcard at the end of the 10th month, reminding families that they will need to reenroll their children. If the county DSS does not receive the form by the end of the 11th month, they send out a "timely notice" saying that their coverage will be terminated if they do not submit the reenrollment form. At the end of the 12th month, coverage is terminated if they have not submitted the reenrollment form. Coverage can be restored if the family brings in all the necessary forms and verification by the 10th day of the following month.[i]

i McClanahan C. Chief, Medicaid Eligibility Unit, Division of Medical Assistance, North Carolina Department of Health and Human Services. Oral communication. December 2008.

North Carolina has already adopted some strategies to simplify its enrollment process. For example, North Carolina has a unified application, enrollment, and recertification process for Medicaid and NC Health Choice. North Carolina simplified its application form (from 18 pages to 4 pages in October 1998), and provides for 12-month continuous eligibility (i.e. once eligible, the child remains eligible for 12 months unless they age out of the program or move away from North Carolina). North Carolina also eliminated the resource test for eligibility for children's programs. However, many eligible children are denied coverage or lose eligibility during recertification because of procedural barriers.

A large number of children enrolled in Medicaid or SCHIP experience gaps in coverage.[8] Research has shown that a significant number of children lose public coverage for procedural reasons.[9] One study found that one-third of all uninsured children in 2006 in the United States had been enrolled in Medicaid or SCHIP the previous year.[10] In North Carolina, more than 40% of NC Health Choice enrollment denials were due to procedural reasons.[11] One quarter of Medicaid and NC Health Choice children lose coverage during recertification. Of these, at least 60% were terminated due to procedural reasons including failure to provide necessary information.[j] Additionally, one study showed that nearly 40% of uninsured children in North Carolina had been enrolled in Medicaid or SCHIP the prior year and were still eligible for public coverage but not enrolled.[10]

One quarter of Medicaid and NC Health Choice children lose coverage during recertification… one study showed that nearly 40% of uninsured children in North Carolina had been enrolled in Medicaid or the State Children's Health Insurance Program the prior year and were still eligible for public coverage but not enrolled.

Children, their families, the state, and providers all suffer adverse consequences from churning—that is, having children lose and regain coverage in short periods of time. Some of the problems include:[8]

- Higher program administrative costs due to having to redetermine eligibility;
- Higher administrative costs for providers who need to reconcile enrollment and billing information for patients with changes in coverage status;
- Additional strain on the safety net, since providers are unlikely to be fully compensated for any care provided to uninsured children;
- Difficulties managing and measuring the quality of care if data needed for managing care are not captured during the period of uninsurance; and
- Delayed, inappropriate, and more costly care.

Several states have adopted strategies to simplify their enrollment and renewal procedures to cover more eligible, uninsured children. These strategies include presumptive eligibility, rolling renewals, administrative verification, coordination

j Data from the North Carolina Division of Medical Assistance. Note: These data are based on cases, not numbers of children. These data only include children who are eligible by reason of Medicaid for Infants and Children (MIC) or NC Health Choice. These data do not include children eligible because their parents are receiving or eligible for Temporary Assistance For Needy Families (TANF), children who are receiving foster care or adoption assistance payments, or children eligible by reason of disability.

with other public programs, and more aggressive follow-up to obtain needed information. In addition, outstationing eligibility workers in other health agencies, and working with community groups to expand outreach activities can also assist in enrollment. Expanding coverage to the parents of low-income children has also been found to be an effective way to enroll eligible children. These strategies are described more fully below:

Several states have adopted strategies to simplify their enrollment and renewal procedures to cover more eligible, uninsured children. These strategies include presumptive eligibility… coordination with other public programs, and more aggressive follow-up to obtain needed information.

- ***Presumptive eligibility:*** Presumptive eligibility is a process whereby certain "qualified entities" can temporarily enroll children who appear to be eligible for Medicaid or SCHIP while the family completes the process for eligibility determination.[k] "Qualified entities" could include clinics, hospitals, schools, and other agencies that determine eligibility for public benefits.[12] North Carolina currently allows presumptive eligibility for pregnant women but not for children. Fourteen other states have adopted presumptive eligibility for children in their Medicaid programs, and eight have adopted it for their SCHIP programs.[13]
- ***Rolling renewals:*** Rolling, or off-cycle renewals makes it easier for a family to reapply at the same time that they are applying (or reapplying) for other public programs, such as Temporary Assistance to Needy Families (TANF), Food Stamps, or Child Care subsidies. Under rolling renewals, families can renew their applications at any time in the year, even if they are not yet due for a renewal. Idaho, Illinois, New York, South Dakota, Washington, and Wisconsin all use rolling renewals.[9]
- ***Web-based renewals:*** Pennsylvania uses an online multi-program application process that allows families to renew coverage any time of the day or day of the week. The system keeps client information for multiple programs and allows those renewing coverage to confirm rather than have to reenter data. Renewal applications can be "e-signed," eliminating the need to mail in paper applications.[9]
- ***Administrative verification:*** Administrative verification enables the Department of Social Services (DSS) office to use administrative databases to verify information that the family would otherwise need to provide. For example, DSS may be able to use information from the Employment Security Commission or Social Security Administration to verify earnings. DSS already uses these sources to verify non-wage income (such as unemployment benefits, Social Security or Supplemental Security Income (SSI) payments). This would reduce the number of applications or recertifications that are closed due to procedural reasons. One of the limitations with this approach is the time lag between the individual's earnings and when earnings are captured in these government databases.
- ***Coordination with other public programs:*** More than 70% of uninsured, low-income children participate in other public programs.[12] Public

k 42 CFR §435.1101, 1102; 447.88; 42 USC §1396r-1.

insurance programs can coordinate with these other programs by instituting referrals between programs, combining enrollment, and sharing information to use for administrative verification. Florida, for example, uses its integrated program database to identify children in the Food Stamp program who are not enrolled in Medicaid. Letters are sent to their households with information about the application process.

North Carolina county DSS staff are already authorized to obtain the necessary verification from other programs administered through DSS (such as food stamps or TANF) if the verification is in the person's eligibility file. However, this approach could be strengthened if DSS were able to accept the income verification determination from another program, and/or coordinate with other public programs, such as the free and reduced cost school lunch program, public housing, or other federal or state programs. Past laws made it difficult to coordinate across federal means tested programs. Last year, the federal SCHIP reauthorization bill would have made it easier for states to coordinate eligibility across these public programs, but the proposed legislation was vetoed by President Bush. The 2009 federal reauthorization of SCHIP allows for use of relevant findings from public programs such as school lunch, food stamps, and the Women, Infants and Children (WIC) program when determining eligibility, enrollment, and renewal.[l,14]

The 2009 federal reauthorization of the State Children's Health Insurance Program allows use of relevant findings from public programs such as school lunch, food stamps, and the Women, Infants and Children (WIC) program when determining eligibility, enrollment, and renewal.

- ***Outreach calls to families:*** Some states have established policies to more actively work with families to help them through the eligibility and re-determination process. For example, outreach calls to families to provide renewal assistance has lead to increased retention in California and Arkansas.[9] California increased the number of reminder calls to families from three to five and increased the variety of call times. This change, along with simplifications made to its forms, increased their SCHIP retention rate by 7%.[9]
- ***Outstationing eligibility workers:*** Federal law requires states to outstation eligibility workers at federally qualified health centers (FQHC) (i.e. community and migrant health centers), and at certain hospitals that serve a lot of uninsured and Medicaid patients.[m] DSS workers are

l Pub L No. 111-003.

m 42 USC § 1396a(a)(55). Federal law requires outstationing of eligibility workers at federally qualified health centers (FQHCs) or Disproportionate Share Hospitals (DSH) to take Medicaid/NC Health Choice applications for pregnant women and children, unless it is "an infrequently used location." The federal letter to the states that describes this requirement notes that "it is unlikely that many DSH hospitals or FQHCs would properly be considered sites infrequently used by pregnant women and children in light of the patient mix at most DSH hospitals and FQHCs." The federal regulations do not define "infrequently used location." States are free to define it, and North Carolina has defined it as a location that serves less than 30 individuals not covered by Medicaid or NC Health Choice in a week.

outstationed at many, but not all, FQHCs in North Carolina.[n,o] The federal government pays 50% of the administrative costs of eligibility workers, and counties pay the remaining 50%. Thus, outstationing eligibility workers could increase the administrative costs to the counties. However, increasing the number of children covered by Medicaid and/or NC Health Choice would bring additional health care dollars into the community. The tax revenues and monies generated from the new federal and state Medicaid and NC Health Choice spending could help offset some or all of the administrative costs that counties incur in outstationing eligibility workers.[15]

- ***Community outreach strategies:*** North Carolina relies heavily on community groups to help with outreach and education at the local level. In the past, staff at the Division of Medical Assistance (DMA), Division of Public Health, North Carolina Pediatric Society, and local DSSs aggressively reached out to community groups to train them in filling out Medicaid and NC Health Choice applications. These community groups could then help individual families fill out the necessary forms to enroll their children. However, some of these outreach activities have been curtailed in recent years because of the state imposed NC Health Choice enrollment cap. More assertive outreach activities could be pursued if the North Carolina General Assembly removes the enrollment cap. South Carolina performed targeted outreach in geographic locations where there were large numbers of children using the emergency department (ED) (identified through their multi-agency data warehouse). They also provided enrollment assistance at targeted EDs. This effort reduced the number of uninsured using EDs by 30%.[16]
- ***Covering low-income parents of eligible children:*** Research has shown that when parents are enrolled in public programs along with their children, drop out rates of children are significantly lower.[17] Eligibility for parents in North Carolina's Medicaid program is below the national average.[13] Thus, one strategy to increase enrollment of eligible children is to expand coverage to their parents. This option is discussed more fully in Chapter 5.

Louisiana made same innovative improvements to their enrollment processes and approach…In 2008, fewer than 1% of children enrolled in Louisiana's LaCHIP program lost coverage for procedural or administrative reasons.

Louisiana uses several of the administrative outreach and simplifications procedures listed above. In 2001, a retention analysis was performed for LaCHIP, Louisiana's combined Medicaid and SCHIP program for children. The report indicated that parents were confused about eligibility requirements as well as enrollment and renewal procedures, paperwork was too cumbersome, and parents were delaying enrollment until there was a medical need.[18]

n In an informal survey of FQHCs across the state, 8 of the 25 centers that responded noted that they had requested that Department of Social Services (DSS) workers be outstationed in their centers, but that DSS failed to do so.

o Money, B. Chief Executive Officer, North Carolina Community Health Center Association. Oral communication. December 2008.

To address these results, Louisiana made some innovative improvements to their enrollment processes and approach. They provided training to eligibility workers to help them better understand the important role they play in reducing the number of uninsured children in the state.[19] They also changed their renewal procedures to a four step process.[20] First, administrative renewals are performed for cases unlikely to have any change in circumstances that would affect eligibility. These renewals are performed without any staff intervention. Next, Louisiana uses an "ex parte" renewal process under which eligibility workers can access information available to the Medicaid agency, such as food stamps and Temporary Assistance for Needy Families (TANF) records and payment data from the Social Security Administration, to verify information needed for renewal. Medicaid eligibility workers were also given increased access to vital records for verification of citizenship. There is no required paperwork if income can be verified through the Department of Labor's database.[19] Additional income verification is collected from employers by phone or fax. They do not require income verification from applicants who declare their income to be below 75% of the eligibility standard.[21] An internal study indicated that this approach did not compromise the integrity of the program.[22] Any additional information needed for enrollment is acquired through telephone calls with families.

Only 10% of Louisiana Medicaid case renewals involve the use of a form. More than half (53%) are performed through ex parte renewals, 15% are done through the administrative renewal process, and 22% are completed over the phone.[21] In Louisiana's SCHIP program, only 15% of renewals require a form, 45% are completed over the phone, and 34% are done through ex parte review. In 2008, fewer than 1% of children enrolled in Louisiana's LaCHIP program lost coverage for procedural or administrative reasons.

By eliminating the cap on NC Health Choice enrollees (see Recommendation 4.2 below), and by implementing several of these outreach and administrative simplification strategies, North Carolina can increase the number of eligible uninsured children who enroll and retain coverage in Medicaid and NC Health Choice. Therefore, the Health Access Study Group recommends:

Recommendation 4.1 (PRIORITY RECOMMENDATION)

a) The North Carolina Division of Medical Assistance (DMA) should simplify the eligibility determination and recertification process to facilitate the enrollment of eligible Medicaid and NC Health Choice individuals. Specifically, DMA should:

1) Pilot test the use of North Carolina administrative databases to verify income, and if accurate, use administrative income databases to verify income for eligibility and recertification for all, or a portion, of the applicants and recipients.

2) Develop a system of presumptive eligibility for children.

3) Allow rolling recertification periods to enable individuals to return their recertification forms anytime within the three months prior to the end of their certification period.

4) **Use eligibility information from other public programs (e.g. food stamps, Women, Infants and Children (WIC), free and reduced school meals) to determine Medicaid and NC Health Choice eligibility.**

5) **Use other efforts to reduce the percentage of procedural closings during the eligibility and recertification process.**

b) **DMA should expand outreach efforts to identify and enroll individuals who are eligible for Medicaid and NC Health Choice. Specifically, DMA should:**

1) **Ensure that the Department of Social Services (DSS) eligibility workers are outstationed at Disproportionate Share Hospitals and federally qualified health centers (as required by federal law), and at health departments or other community health providers that serve a large number of potentially eligible Medicaid recipients. Outstationed DSS workers should help individuals fill out Medicaid and NC Health Choice applications and recertification forms and determine eligibility.**

2) **Train community organizations and other health professionals to assist potentially eligible individuals in filling out applications and recertification forms.**

c) **The Department of Public Instruction and Local Education Authorities should actively work to promote health insurance coverage to children eligible for public programs, in coordination with the outreach efforts of the Department of Health and Human Services and local DSSs.**

Expanding Health Insurance Coverage to Children in Families with Higher Incomes

As noted previously, low-income children—those with incomes less than 200% FPG—are most likely to be uninsured. However, there has been a large growth in the percentage of children with family incomes of between 200%-300% FPG. (See Figure 4.5.)

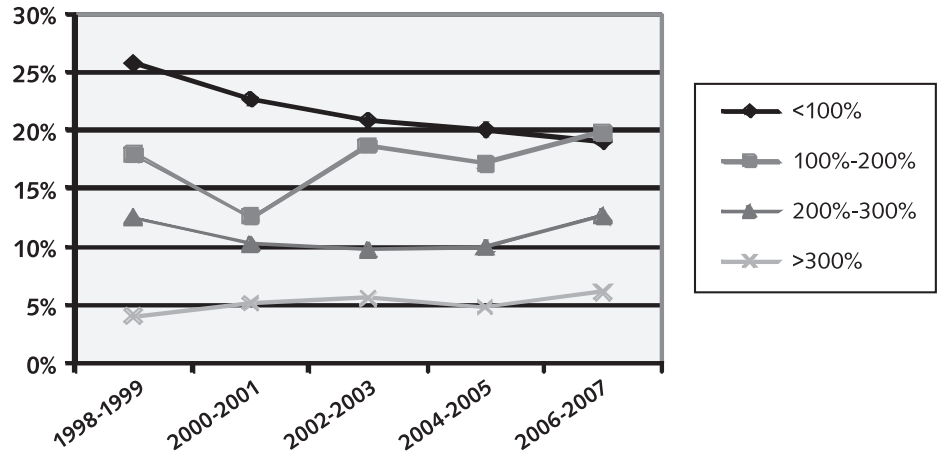
In 2007, there were 19 states (including the District of Columbia) that covered children in families with incomes greater than 200% of the federal poverty guidelines.

North Carolina is one of 23 states that cover children with family incomes equal to or less than 200% FPG through Medicaid or SCHIP.[13] Several states have expanded coverage to children with higher incomes in order to cover more uninsured children.[p] In 2007, there were 19 states (including the District of Columbia) that covered children in families with incomes greater than 200% FPG. Of these:

- Three covered children in families with incomes between 201%–249% FPG,
- Six covered children in families with incomes between 250%–299% FPG, and

p States can effectively increase the income guidelines for children by using "less restrictive income and resource methodologies." 42 USC §§1396u-1(b)(2)(c), 1396a(r)(2) (Medicaid) and 1397 (State Children's Health Insurance Program).

Figure 4.5
Percent Middle-Income Uninsured Children Has Grown Between 2000-2001 and 2006-2007



Source: North Carolina Institute of Medicine. Analysis of the US Census Bureau, Current Population Survey's Annual Social and Economic Supplement, 2006-2007.

- Ten (including the District of Columbia) covered children in families with incomes up to 300% FPG or more.[q,13]

In North Carolina, an additional 9% of uninsured children (~29,000) could be covered through program expansion to 250% FPG, and 14% (~46,000) children through expansion to 300% FPG.[4]

In North Carolina, an additional 9% of uninsured children (~29,000) could be covered through program expansion to 250% of the federal poverty guidelines (FPG), and 14% (~46,000) through expansion to 300% FPG.

In the 2008 Session, the North Carolina General Assembly gave the Division of Medical Assistance (DMA) the authority to implement NC Kids' Care, a publicly-subsidized health insurance program for uninsured children with family incomes between 200%-250% FPG.[r,s] The program will be a block grant, and coverage will be limited to 15,000 children. Implementation was delayed until the reauthorization of federal SCHIP. NC Kids' Care will be similar to, but have different cost sharing and benefits than NC Health Choice. Cost sharing (premiums, co-payments, and deductibles) will vary according to family income with overall cost sharing capped at five percent of family income.[22] The benefit package will be similar to NC Health Choice, with the exception of dental, which will not be covered.[23]

q States covering children with family incomes up to 300% of the federal poverty guidelines (FPG) include Connecticut, District of Columbia, Hawaii, Maryland, Massachusetts, Missouri, New Hampshire, New Jersey, Pennsylvania, and Vermont.

r The North Carolina General Assembly first created the program in the 2007 Session. At that time, the General Assembly directed the Division of Medical Assistance (DMA) to develop a plan, called NC Kids' Care, to expand health insurance coverage to uninsured children between 200%-300% FPG. DMA was required to report its recommendations back to the 2008 Session. (Sec. 10.48 of Session Law 2007-323.) In the 2008 Session, the General Assembly limited eligibility to children with incomes between 200%-250% FPG.

s Section 10.12(c) of Session Law 2008-107.

In addition to raising the income limits to cover all eligible children below a certain income, states can also target their expansion to cover disabled children. In 2006, the federal government adopted the Family Opportunity Act (part of the Deficit Reduction Act of 2005), which allows states to cover disabled children up to 300% FPG under Medicaid. Coverage under this program will be phased in by age starting with children up to age six in 2007 and rising to age 19 by 2009. States can charge sliding scale premiums to parents, however total premiums and cost sharing under the plan cannot exceed five percent of family income for children in families with incomes below 200% FPG and 7.5% for those children in families with incomes between 200%-300% FPG. Parents are required to participate in family employer-sponsored insurance if the employer covers at least 50% of the premium. Medicaid premiums must be reduced to reflect the premium cost attributable to the disabled child, if the family is covered by an employer-sponsored plan.[24] One major difference between the Family Opportunity Act and SCHIP coverage (NC Health Choice or NC Kids' Care) is that children may have private health insurance coverage and still qualify for Medicaid to pay for services not otherwise covered through the private health plan. This is particularly helpful for children with special health needs.

To expand coverage to include more low-income children, the Health Access Study Group recommended:

Recommendation 4.2 (PRIORITY RECOMMENDATION)

The North Carolina General Assembly should:

a) **Remove the cap on coverage of eligible children in the NC Health Choice program.**

b) **Continue to implement NC Kids' Care with coverage of children up to 250% of the federal poverty guidelines (FPG). If sufficient federal and state funds are available, NC Kids' Care should be expanded to cover children up to 300% FPG.**

Recommendation 4.3

The North Carolina General Assembly should expand Medicaid to implement the Family Opportunity Act which allows children who meet the Supplemental Security Income disability standards with family incomes of up to 300% of the federal poverty guidelines to buy-into the Medicaid program.

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