Adults with incomes less than 200% of the federal poverty guidelines (FPG) comprise almost half (46%) of all non-elderly uninsured in North Carolina. This amounted to 705,000 uninsured adults in the state in 2006-2007.[a] Most of these low-income adults work: 42% work full-time and 17% work part-time. Approximately 58,000 of the low-income, uninsured adults who are not working full-time have a spouse working full-time. Low-income, uninsured, full-time workers are more likely to work in small firms than similar workers with incomes above 200% FPG (33% in small firms vs. 26% in larger firms). Additionally, they are twice as likely as full-time workers with higher incomes to work in agriculture, construction, and hospitality, which are the industries with the highest uninsurance rates among full-time workers.

Adults with incomes less than 200% of the federal poverty guidelines (FPG) comprise almost half (46%) of all non-elderly uninsured in North Carolina.

The Health Access Study Group explored two options to expand publicly-subsidized coverage to low-income adults (defined as having a family income up to 200% FPG): a Medicaid expansion or a subsidy for low-income adults with pre-existing conditions to enable them to pay for health insurance coverage through the high-risk pool. Both options are discussed in more detail below.

Medicaid Expansion

Unlike low-income, uninsured children, of whom most are already eligible but not enrolled in either Medicaid or NC Health Choice, low-income, uninsured adults are generally not eligible for public coverage.[b] (See Figure 5.1.) Medicaid eligibility is generally limited to certain "categories" of low-income individuals. For adults, this includes pregnant women, adults who are parents of dependent children under age 19, and adults who are disabled or at least 65 years old.[c] There are proposals being discussed in Congress which would eliminate these categorical restrictions and expand Medicaid to cover all low-income adults—regardless of whether they are a parent or childless adult.[1] However, under existing federal Medicaid laws, states cannot cover low-income, childless adults who are not pregnant, disabled, or elderly unless they obtain a waiver of federal Medicaid laws.

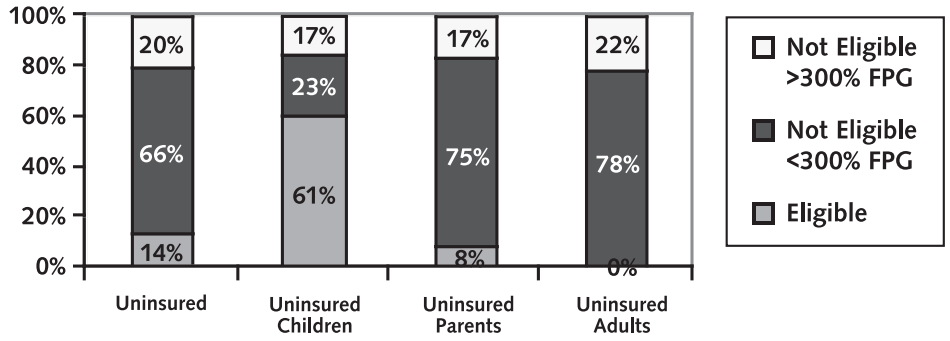
Although most childless adults cannot currently be covered through Medicaid without a federal waiver, low-income parents can be covered. States set the income and resource eligibility requirements for parent coverage, as they do for other eligible groups. North Carolina's income eligibility limits are based on gross income, with some allowable deductions, which are more generous for people with earned income than those without income or with only unearned income

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.

b State Children's Health Insurance Program programs are generally limited to coverage of uninsured children (although some states with unspent federal monies were able to obtain waivers to cover uninsured parents through their State Children's Health Insurance Program).

c There are certain limited Medicaid programs which cover certain categories of low-income adults who are not disabled or elderly. For example, North Carolina provides family planning coverage to certain low-income adults with incomes up to 185% of the federal poverty guidelines. In addition, under certain circumstances, North Carolina also provides coverage to women who have been diagnosed with breast or cervical cancer.

Figure 5.1
Most Adults are not Eligible for Existing Public Programs in North Carolina

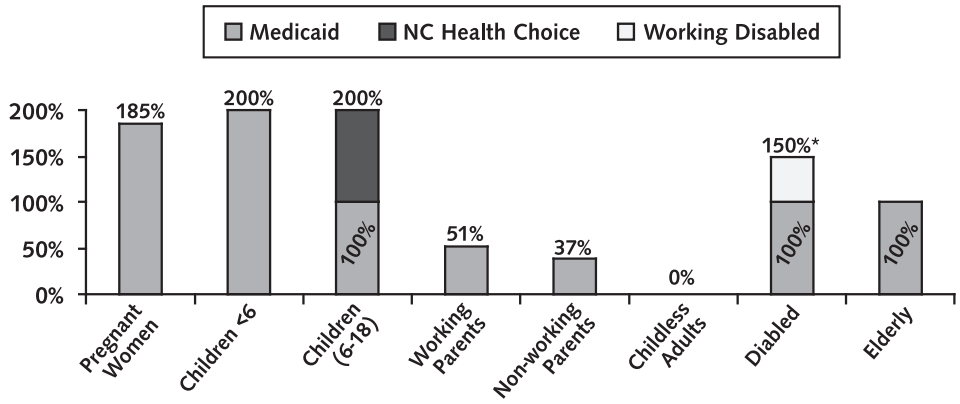


Source: North Carolina Institute of Medicine. Analysis of the US Census Bureau, Current Population Survey's Annual Social and Economic Supplement, 2006-2007.

North Carolina's Medicaid maximum income limits for parents are much more restrictive than they are for other eligibility groups.

(such as Supplemental Security Income or unemployment compensation). As seen below in Figure 5.2, North Carolina's Medicaid maximum income limits for parents are much more restrictive than they are for other eligibility groups.

Figure 5.2
North Carolina Medicaid and NC Health Choice Maximum Income Limits for Parents are More Restriction than for Other Groups



Source: Medicaid & CHIP. Statehealthfacts.org, Henry J. Kaiser Family Foundation website. http://www.statehealthfacts.org/profilecat.jsp?rgn=35&cat=4. Accessed March 3, 2009. Based on a family of three in 2008.

*Working disabled individuals can have incomes up to 150% FPG and still qualify for Medicaid. In the future, eligibility will be expanded further to cover disabled individuals with higher incomes (earned or unearned). These individuals will pay sliding scale premiums and cost sharing.

To qualify for Medicaid in North Carolina, a working *parent* with two children must have an income at or below $9,000 (or about half FPG), and a non-working *parent's* income must be at or below $6,528/year (or a little more than one-third FPG).[2] (See Table 5.1.) North Carolina's income threshold for parent eligibility is lower than both the median for the United States and two of its neighboring states, South Carolina and Tennessee.[2] (See Table 5.1.)

Table 5.1
North Carolina Family Income Eligibility Limits for Parents is Lower than the National Median

	Income threshold for non-working parents		Income threshold for working parents	
	Annual dollar amount*	Percent of poverty	Annual dollar amount*	Percent of poverty
US Median	$7,200	41%	$11,928	68%
North Carolina	$6,528	37%	$9,000	51%
Georgia	$5,088	29%	$9,072	52%
South Carolina	$8,580	49%	$15,864	90%
Tennessee	$12,916	73%	$23,628	134%
Virginia	$4,272	24%	$5,352	30%

Source: Medicaid & CHIP. Statehealthfacts.org, Henry J. Kaiser Family Foundation website. http://www.statehealthfacts.org/comparetable.jsp?ind=205&cat=4. Accessed March 12, 2009. Based on a family of three in 2008.

North Carolina also limits the amount of resources an adult can have and still qualify for Medicaid. Countable resources (assets) include money in the bank and most other financial assets that can be easily converted to cash. In North Carolina, a parent can have no more than $3,000 in countable resources for a family of three or $4,000 for a family of four.

Federal Medicaid Relief to the States

Program expansion to cover new eligibles will be difficult during this time of economic upheaval. Therefore, the Health Access Study Group recommended that Congress provide fiscal relief to the states to help the states pay for their growing Medicaid costs. Medicaid is typically considered a countercyclical program—that is, the number of Medicaid recipients grows when the economy gets worse. For example, every 1% increase in the national unemployment rate leads to an increase of approximately one million people in Medicaid and the State Children's Health Insurance Program (SCHIP), an additional 1.1 million uninsured, and a three to four percent decline in state revenues.[3]

Medicaid is typically considered a countercyclical program—that is, the number of Medicaid recipients grows when the economy gets worse.

The negative impact on states' budgets is exacerbated during the first few years of any recession. The current federal Medicaid match rate (federal medical assistance percentage, or FMAP) is calculated based on a state's per capita income compared to the national per capita income, so that states with lower per capita income receive a higher federal match than states with higher per capita incomes.[4] The

FMAP rate is calculated each year, based on a time-lagged three year period. Thus, the FY 2009 FMAP rates were based on the state's per capita income from 2004-2006, when the state's economy was more robust. The confluence of these two factors—growing numbers of eligibles and low FMAP rates—creates major budgetary problems for states, as the states have fewer revenues to pay for growing Medicaid program costs. The federal government gave states a temporary 2.95% increase to the federal medical assistance payment match rate during the last recession (2003-2004), in order to provide fiscal relief to the states.[d,5] Congress is considering providing Medicaid relief as part of a new economic stimulus package.[6] The Health Access Study Group strongly supports a Medicaid fiscal relief package for the states. In addition, the Health Access Study Group also recommends programmatic changes eliminating the categorical eligibility restrictions, which limits coverage of low-income adults to certain "categories" of individuals (including pregnant women, parents of dependent children, people who are disabled or people age 65 or older). Instead, federal Medicaid funds should be available to cover all low-income adults (as it is for children and people over age 65).

To provide fiscal relief to the states, and expand Medicaid laws to allow states to cover all low-income adults, the Health Access Study Group recommends:

Recommendation 5.1 (PRIORITY RECOMMENDATION)

The North Carolina General Assembly and the Governor's Office should work with the North Carolina Congressional delegation to support Medicaid reform that provides fiscal relief to the states and gives states the flexibility and funding to expand coverage to low-income adults without categorical restrictions, along with other efforts to provide an economic stimulus to the state.[e]

Estimates from the Current Population Survey suggest that approximately 30,000 of uninsured adults are already income eligible for Medicaid.

Expanding Outreach and Program Simplification

As noted earlier, there were approximately 693,000 uninsured, low-income adults in North Carolina in 2006-2007. With rising health insurance costs and the downturn in the economy, there are probably many more uninsured, low-income adults today. As with children, some of these low-income adults are already eligible for, but not enrolled in, Medicaid. Estimates from the Current Population Survey suggest that approximately 30,000 of uninsured adults are already income eligible for Medicaid—that is, they have incomes less than approximately 50% FPG and have their children, under age 19, living in the household. As with children, one way to identify and enroll people who are currently eligible for Medicaid is to engage in more aggressive outreach to potentially eligible populations. Another is

d The 2.95 percent increase in the federal medical assistance percentage (FMAP) rates amounted to $10 billion in federal assistance to the states. States had to maintain existing eligibility levels in order to receive the enhanced FMAP rate. However, states still had the authority to make other programmatic cuts, such as eliminating optional services or freezing provider payment levels and still qualify for the enhanced match rate.

e Following the conclusion of the meeting of the Health Access Study Group, Congress passed the American Recovery and Reinvestment Act of 2009 (Pub L No. 111-005) that provids fiscal relief to the states to help pay for increasing Medicaid enrollment (including a general 6.2% in the federal medical assistance percentage (FMAP)). The Study Group supports the Recovery Act.

to simplify the application and recertification procedures. For example, North Carolina could eliminate the resource test for parents, as it has for children and pregnant women. Twenty-two other states have already taken this step.[2] Data from the Division of Medical Assistance show that last year, local Departments of Social Services determined eligibility for almost 250,000 cases involving low-income parents (who were not also receiving Temporary Assistance to Needy Families (TANF)). Fewer than 0.2% were denied (639 cases or 986 people) because they had excess resources. Eliminating the resource limit would streamline the eligibility process and reduce administrative costs to the counties.[f] North Carolina could also increase the resource limits for other eligibility groups, enabling people with disabilities or older adults to qualify. North Carolina could also extend the certification period for parents from six months to 12 months, as have 40 other states.[2] To further simplify enrollment and more aggressively seek to enroll eligible parents, the Health Access Study Group recommends:

Recommendation 5.2 (PRIORITY RECOMMENDATION)

The North Carolina Division of Medical Assistance (DMA) should conduct outreach activities and simplify the eligibility determination and recertification process to facilitate the enrollment of adults eligible for Medicaid. In addition to efforts undertaken for children, DMA should explore other options applicable to adults, including, but not limited to: eliminating the resource limits for low-income parents or childless adults with incomes below 100% of the federal poverty guidelines, expanding the allowable resource limits for other Medicaid eligibles, and increasing the certification period from 6 to 12-months.

Expanding Medicaid to Cover New Eligibles

The Health Access Study Group explored other options to expand Medicaid coverage to low-income, uninsured adults in the most cost-effective way possible. The Health Access Study Group supports further Medicaid expansion, as the federal government pays approximately 65% of program costs (with the state responsible for the remaining 35%).[g,h] The state has two options to expand coverage to low income adults: expand the income limits for low-income parents or seek a Medicaid waiver to enable the state to cover all low-income adults, including childless, non-disabled, non-elderly adults.

Approximately one-fifth of low-income, uninsured adults could qualify for Medicaid if the state increased income limits up to 200% of the federal poverty guidelines.

Expanding Medicaid to cover more low-income parents: Approximately one-fifth of low-income, uninsured adults could qualify for Medicaid if the state increased income limits up to 200% FPG. Estimates from the Current Population Survey suggest that there are another 83,000 uninsured parents of children under age 19

f Currently, the counties pay the 50% non-federal match for county eligibility workers.

g The FFY 2009 federal medical assistance percentage (FMAP) rates can be found at: 72 Fed. Reg. 67304 (Nov. 28, 2007). North Carolina's current FMAP rate (FFY 2009) is: 64.60. The FFY 2010 FMAP rates are at: 73 Fed. Reg. 72051 (Nov. 26, 2008). North Carolina's FFY 2010 FMAP rate is expected to be 65.13.

h FFY 2009 federal medical assistance percentage (FMAP) rates were increased following the passage of the the American Recovery and Reinvestment Act of 2009 (Pub L No. 111-005)

with incomes between 50%-100% FPG and 139,000 with incomes between 100%-200% FPG.[7] North Carolina could increase the income limits for parents without seeking a Medicaid waiver. This would require additional state funds.

Medicaid generally operates as an entitlement program; states are required to cover all eligibles regardless of overall program costs. While states do have options to reduce Medicaid costs, including cutting services, cutting eligibles, freezing or reducing provider payments, or more stringent medical management, North Carolina would still be responsible for coming up with the state match to cover the program expansion for anyone who was eligible under the state's eligibility rules. Absent a waiver, states cannot impose an enrollment cap to limit program growth.

Under a federal Medicaid Section 1115 waiver, states can expand coverage to both low-income parents and to childless adults—potentially covering up to 692,000 uninsured, low-income adults.

Medicaid Section 1115 waiver to cover all low-income adults: Rather than support regular Medicaid expansion, the Health Access Study Group recommended that the state pursue a federal Section 1115 Medicaid waiver to expand coverage to low-income adults. Under this option, states can expand coverage to both low-income parents and to childless adults—potentially covering up to 692,000 uninsured, low-income adults. However, to obtain a waiver, the state must be able to demonstrate cost neutrality to the federal government. Thus, the state must find "savings" to offset the additional costs of program expansion.

The Health Access Study Group recommended that the Division of Medical Assistance (DMA) pursue an 1115 waiver. To limit the costs of the expansion, the Study Group recommended that DMA develop a limited benefit package, enroll Medicaid recipients into Community Care of North Carolina (CCNC), and offer a premium assistance program. North Carolina may be able to show budget neutrality by using program savings the state anticipates will come from expanding CCNC to cover the elderly and disabled. In addition, the state can set a cap on program expenditures or new eligibles under an 1115 waiver. Each of these issues is discussed more fully below.

- ***Limited benefit packages:*** North Carolina can use an 1115 waiver to limit the benefits covered to individuals enrolled in Medicaid. In 2006, the NCIOM Task Force on Covering the Uninsured recommended that North Carolina develop a limited benefit package which emphasizes prevention, primary care, and chronic disease management (and which provides limited coverage of inpatient and outpatient hospitalizations).[i,j] The goal is to help provide the care needed to reduce the need for hospitalizations. DMA should develop a lower cost benefit package, similar to the one described, to offer to low-income adults, which would limit the cost of program expansion.

i North Carolina Institute of Medicine. Expanding Health Insurance Coverage to More North Carolinians. North Carolina Task Force on Covering the Uninsured: April 2006, Durham, NC. April 2006.

j In 2006, Congress enacted the Deficit Reduction Act (DRA), which gave states the ability to limit the benefit package for different groups of eligibles. (Deficit Reduction Act of 2005: Implications for Medicaid. Kaiser Commission on Medicaid and the Uninsured. February 2006). However, the DRA does not allow states to offer this more limited benefit package to groups of eligibles who were not already covered at the time that the DRA was enacted. Thus, North Carolina may need a waiver in order to limit the benefit package.

- ***Premium assistance programs:*** States have the option of using Medicaid dollars to subsidize private health insurance coverage for Medicaid-eligible individuals if it is cost-effective to the state.[k] Most states that operate premium assistance programs use Medicaid funds to help subsidize the employee share of employer-sponsored insurance (ESI). The state benefits from the employer's contributions towards the cost of the health insurance premium, thus reducing the state's Medicaid costs. Some states also use Medicaid funds to help individuals purchase non-group coverage, although it is harder to show that this is cost-effective to the state as there are no employer contributions to non-group coverage.[8]

  North Carolina does not currently operate a premium assistance program. Because of the state's restrictive Medicaid eligibility rules, few people would qualify for both Medicaid coverage and ESI. Most states that have implemented premium assistance programs have higher income eligibility limits for adults. In these states, low-wage, full-time workers might be able to qualify for Medicaid. Some of these workers may have access to ESI. However, even then, most states have had limited enrollment, as many low-income Medicaid eligibles work for small employers that do not offer insurance.[8,9]

  To address this issue, some states have combined premium assistance programs with initiatives to expand health insurance coverage to small employers. New Mexico and Oklahoma have pursued this approach. Both states have developed private-public health insurance plans that are based on their Medicaid managed care programs and have offered this coverage to small employers. North Carolina could pursue a similar approach, working with private insurers to offer a low cost insurance product provided through the Community Care of North Carolina (CCNC) networks and that focuses on prevention, primary care, and chronic disease management. (CCNC is described more fully in Chapter 3.) These plans can be limited to employers that have not previously offered health insurance. The state could then use Medicaid funds for Medicaid recipients to help offset the employees' share of insurance premiums.

- ***Cost neutrality:*** As noted previously, one of the requirements of an 1115 waiver is to show budget neutrality to the federal government. That is, the state must identify sufficient savings to offset any new federal costs due to program expansion. In 2005, the North Carolina General Assembly directed DMA to expand the CCNC chronic disease management system to Medicaid recipients who are aged, blind, or disabled. CCNC has started to enroll some of these recipients, but the program has not been fully extended to all of the aged, blind, and disabled. If North Carolina

One of the requirements of an 1115 waiver is to show budget neutrality…the state must identify sufficient savings to offset any new federal costs due to program expansion.

k States may also use State Children's Health Insurance Program (SCHIP) funding to create a premium assistance program. States that operate SCHIP premium assistance programs can use SCHIP funds to purchase family coverage, if cost effective to the state (i.e. the family share of family coverage is less than the state would have spent on coverage for the child or children).

pursues an 1115 waiver before the program is fully implemented, some of the future program savings may be able to be used to demonstrate cost neutrality to the federal government.

- ***Program caps:*** One of the other advantages of an 1115 waiver from the state's fiscal perspective is that it can cap numbers of eligibles or expenditures for the new group of eligibles. This is particularly important to the state during fiscal shortfalls, as the state has more limited revenues to apply to program expansion.

Given the state's current budget constraints due to the recession, the Health Access Study Group recommended a phased-in expansion to low-income adults through an 1115 waiver. The Health Access Study Group recommends:

Recommendation 5.3 (PRIORITY RECOMMENDATION)

The North Carolina General Assembly should direct the Division of Medical Assistance (DMA) to seek a Medicaid Section 1115 waiver to cover more low-income adults. The waiver should be implemented in two phases.

a) **The first phase should be to expand Medicaid coverage to low-income adults with incomes below 100% of the federal poverty guidelines (FPG).**
    1) **DMA should develop a limited benefit package that emphasizes prevention, primary care, chronic disease management, a limited formulary, and limited hospitalizations.**
    2) **Adults covered under this initiative should be enrolled in Community Care of North Carolina (CCNC).**
    3) **DMA should seek to identify other state funds already being used to provide services to this population that could be used as part of the state match for this new Medicaid coverage.**

b) **The second phase should be to expand coverage to adults with incomes between 100%-200% FPG.**
    1) **The adults covered through this waiver should receive the same benefit package and be enrolled in CCNC.**
    2) **DMA should develop a sliding scale for premiums and cost sharing for this group. However, in no event can the combined premium or cost sharing exceed 5% of the families gross income.**

c) **DMA should develop a premium assistance program to enable Medicaid-eligible recipients to use Medicaid funds to pay for employer-sponsored insurance or private non-group insurance purchased in the private market.**

d) In order to expand the availability of coverage in the small group market, DMA should work with North Carolina Community Care Network, Inc. and private insurers to explore the potential for a lower cost insurance product for small employers that do not offer insurance, utilizing the CCNC network. Medicaid-eligible recipients who work for employers who enroll in this lower-cost public-private partnership plan shall also be eligible for premium assistance. The product may include the following features:

1) Connecting all enrollees with a medical home;

2) A more limited benefit package, emphasizing prevention, primary care, and chronic disease management;

3) Ensuring that enrollees with chronic diseases or complex health problems have access to care management and disease management through CCNC networks;

4) An emphasis on wellness, health promotion, and personal responsibility;

5) Provider reimbursement for low-income populations with incomes <200% FPG at lower levels than commercial rates;

6) A requirement that small employers that purchase health insurance coverage through this public-private partnership also offer Section 125 plans.[l]

North Carolina has one of the highest infant mortality rates in the country, ranking 45th in the nation in 2005.

The Health Access Study Group also recommended that the state explore a more limited 1115 Medicaid waiver for women who have had a prior high-risk birth. North Carolina has one of the highest infant mortality rates in the country, ranking 45th in the nation in 2005.[10] This is due, in part, to the number of children who are born preterm. Infants born before their 34th week have a much higher likelihood of being low or very low-birthweight (less than 1500 grams for very low-birthweight), and being born with congenital abnormalities. In 2005, among North Carolina Medicaid births there were 2,140 infants born prematurely (under 34 weeks), 1,217 infants born who were very low birthweight (under 1500 grams), and 1,622 infants born with congenital abnormalities. There were also 263 neonatal infant deaths. In total, there were 3,523 unduplicated high-risk births.

Having a prior preterm birth is one of the strongest predictors of preterm birth.[11] That is because many of the factors contributing to preterm birth, such as chronic illnesses or poor health status, continue after the delivery. North Carolina already has an 1115 family planning waiver that provides family planning services to women with incomes up to 185% FPG.[m] Under the terms of the federal waiver, the state can only cover family planning services and very limited treatment of sexually transmitted diseases. The Medicaid family planning waiver cannot be expanded to provide more comprehensive coverage to women to help them manage chronic

l Section 125 plans are described more fully in Chapter 6.

m The family planning waiver provides family planning services to men between the ages of 19 and 60 and women between the ages of 19 and 55 with incomes below 185% FPG. There is no resource test for this program.

illnesses so that they can be healthy for a subsequent birth. Women who have had a high-risk pregnancy should be provided interconceptional care that includes, at a minimum, treatment of chronic illnesses (such as diabetes or substance abuse), infections, depression, genetic testing, and counseling for diet.[12]

Medicaid pays anywhere from eight to 15 times more for a high-risk birth than for a normal birth. (See Table 5.2.) The state can reduce the number of high-risk births by improving the interconceptional care of the mother. Dunlop et al. conducted a study to determine whether providing interconceptional care to women who had a prior preterm birth would improve subsequent birth outcomes.[13] Study participants were provided medical, dental, and supportive services for two years following their initial delivery. Dunlop found that the women who did not receive the interconceptional care (control group) had 3.5 times as many adverse pregnancy outcomes and 2.6 times as many repeat high-risk pregnancies as the women who were offered comprehensive services.

The state can reduce the number of high-risk births by improving the interconceptional care of the mother.

Table 5.2
Medicaid Pays 8-15 Times More for High-Risk Births than for Normal Births (365 days, 2005)

	Birth with Risk Factor		Normal Birth without Risk Factor	
Risk Factor	Number	Average Medicaid cost first year of life	Number	Average Medicaid cost first year of life
Preterm Birth (less than 34 weeks)	2,140	$44,738.41	47,241	$4,065.00
Very Low Birth Weight (<1500 grams)	1,217	$63,877.32	48,164	$4,360.85
Congenital Abnormality	1,622	$34,713.15	47,759	$4,846.63
Neonatal Infant Death (within 28 days of birth)	263	$16,581.19	49,118	$5,770.06
Total At-risk Birth	3,523	$36.976.61	45,858	$3,434.65

Source: 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. Based on a family of three in 2008.

If North Carolina is not able to expand Medicaid coverage to all low-income adults, the Health Access Study Group recommends a more limited expansion to women who have had a high-risk pregnancy in the prior two years. In order to improve birth outcomes, North Carolina should develop an 1115 waiver to provide interconceptional care for up to two years for all Medicaid-eligible women with incomes up to 185% FPG who have a high-risk birth. Therefore, the Health Access Study Group recommends:

Recommendation 5.4 (PRIORITY RECOMMENDATION)

The North Carolina General Assembly should direct the Division of Medical Assistance (DMA) to seek a Medicaid Section 1115 waiver or implement other Medicaid options to provide interconceptional coverage to low-income women with incomes below 185% of the federal poverty guidelines who have had a high-risk birth. (For purposes of this recommendation, high-risk births are those with infants weighing less than 1500 grams, born less than 34 weeks gestation, born with a congenital anomaly, and/or who has died in the neonatal period (first 28 days of life) within the past two years).

a) **Interconceptional care should be limited to two years following the birth, or until the subsequent birth, whichever occurs sooner.**

b) **DMA should develop a benefit package to improve interconceptional care in order to decrease poor birth outcomes in subsequent pregnancies.**

c) **DMA should explore whether the cost savings from improved health outcomes will offset the cost of providing Medicaid coverage to this targeted population.**

Subsidizing the Costs Of Coverage in the High-Risk Pool

In 2007, the North Carolina General Assembly enacted legislation to create the North Carolina Health Insurance Risk Pool (now known as Inclusive Health).[n] The risk pool provides coverage to individuals who cannot obtain affordable health insurance coverage in the non-group (individual) market because they have a pre-existing medical condition. Benefits are similar to those available in the non-group market, and have annual deductibles starting at $1,000 and a lifetime maximum of $1,000,000. Premiums are set at 175% of the average premium that a person with a standard health risk would pay for similar coverage. Premiums vary by age, gender, and smoker status.

Under the legislation, the Pool's board is required to review methods for providing a premium subsidy on a sliding scale basis for individuals with incomes up to 300% FPG.[o] North Carolina is one of 35 states with a health insurance risk pool. Fourteen of these states provide additional subsidies to help low-income individuals pay for the high-risk pool premium.[14] State pools with low-income subsidies tend to have higher penetration than those without a low-income subsidy. On average, pools with low-income subsidies cover roughly 0.2% of the state's total population and 1.5% of the state's uninsured, compared to less than 0.1% of the population and 0.4% of the uninsured in states with no low-income subsidies.

On average, high risk pools with low-income subsidies cover roughly 0.2% of the state's total population and 1.5% of the state's uninsured, compared to less than 0.1% of the population and 0.4% of the uninsured in states with no low-income subsidies.

n NCGS §58-50-180.
o NCGS §58-50-255.

Premium subsidies in most states provide limited discounts to low-income individuals. The goal is to help make premiums affordable, but to keep the premiums above the standard rate so that the subsidized product does not compete with the private insurance market. Leif and Associates, the actuaries for Inclusive Health, estimated that it would cost $1 million for every 500 low-income people enrolling in the high-risk pool.[p,15] Leif and Associates assumed that the high-risk pool will cover approximately 9,000 people once fully implemented without a premium subsidy. If North Carolina's experience is similar to other states, we might expect an additional 9,000 people to be covered with a premium subsidy. The total annual cost for this premium subsidy would be $18 million/year.

Recommendation 5.5

The North Carolina General Assembly should revise North Carolina General Statute §58-50-180(d) to clarify that the North Carolina Health Insurance Risk Pool has the legal authority to offer premium subsidies.

a) **The North Carolina General Assembly should appropriate $18 million in recurring funds to help subsidize, on a sliding-scale basis, the Pool premium for low-income persons with incomes below 300% of the federal poverty guidelines.**

b) **The Pool should pursue sources of funding for premium subsidies, including but not limited to philanthropic foundations, to supplement any state funds appropriated for that purpose.**

p Leif and Associates assumed a 43% premium subsidy for individuals with incomes between below 200% FPG, and a 20% subsidy for people with incomes between 200%-300% FPG. This would reduce the premiums to 100% of the standard risk for the lower income individuals, and 140% of the standard risk for people with incomes between 200%-300% FPG. The estimate assumes an equal number of participants from each of the two income categories.

References

1 Baucus M. Call to action: health reform 2009. http://www.finance.senate.gov/healthreform2009/finalwhitepaper.pdf. Published November 12, 2008. Accessed January 5, 2008.

2 Ross DC, Horn A, Marks C; Kaiser Commission on Medicaid and the Uninsured, Henry J. Kaiser Family Foundation. Health coverage for children and families in Medicaid and SCHIP: state efforts face new hurdles. http://www.kff.org/medicaid/upload/7740.pdf. Published January 2008. Accessed November 7, 2008.

3 Dorn S, Garrett B, Holahan J, Willaims A; Kaiser Commission on Medicaid and the Uninsured, Henry J. Kaiser Family Foundation. Medicaid, SCHIP, and economic downturn: policy changes and policy responses. http://www.kff.org/medicaid/upload/7770.pdf. Published April 2008. Accessed January 5, 2009.

4 Smith V, Gifford K, Ellis E, Rudowitz R, O'Malley M, Marks C; Kaiser Commission on Medicaid and the Uninsured, Henry J. Kaiser Family Foundation. Headed for a crunch: an update on Medicaid spending, coverage and policy heading into an economic downturn. http://www.kff.org/medicaid/upload/7815.pdf. Published September 2008. Accessed January 5, 2009.

5 Wachino V, O'Malley M, Rudowitz R; Kaiser Commission on Medicaid and the Uninsured, Henry J. Kaiser Family Foundation. Financing health coverage: the fiscal relief experience. http://www.kff.org/medicaid/upload/Financing-Health-Coverage-The-Fiscal-Relief-Experience-Policy-Brief.pdf. Published November 2005. Accessed January 9, 2009.

6 Elliott P, Taylor A. Obama: country needs economic stimulus plan. *News and Observer.* January 3, 2009:http://www.newsobserver.com/1566/story/1353415.html. Accessed January 5, 2009.

7 Holmes M. Analysis of US census, Current Population Survey 2006-2007.

8 Silberman P, Brogan L, Moore C, Slifkin R; North Carolina Rural Health Research and Policy Analysis Center, Cecil G. Sheps Center for Health Services Research. Premium assistance: how well does it work in rural areas. http://www.shepscenter.unc.edu/research_programs/rural_program/pubs/report/WP85.pdf. Published January 2006. Accessed January 5, 2009.

9 Alker J; Kaiser Commission on Medicaid and the Uninsured, Henry J. Kaiser Family Foundation. Choosing premium assistance: what does state experience tell us? http://www.kff.org/medicaid/upload/7782.pdf. Published May 2008. Accessed January 5, 2009.

10 Matthews TJ, MacDorman MF. Infant mortality statistics from the 2005 period linked birth/infant death data set. *National Vital Statistics Report.* 2008;57(2).

11 Haas JS, Fuentes-Afflick E, Stewart AL, et al. Prepregnancy health status and the risk of preterm delivery. *Arch Pediatr Adolesc Med.* 2005;159(1):58-63.

12 Dunlop AL, Jack BW, Bottalico JN, et al. The clinical content of preconception care: Women with chronic medical conditions. *Obstet Gynecol.* 2008;199(6):S310-S327.

13 Dunlop AL, Dubin C, Raynor BD, Bugg GW, Schmotzer B, Brann AW. Interpregnancy primary care and social support for african-american women at risk for recurrent very-low-birthweight delivery: a pilot evaluation. *Matern Child Health J.* 2008;12(4):461-468.

14 National Association of State Comprehensive Health Insurance Plans, Leif Associates. Comprehensive health insurance for high-risk individuals: a state-by-state analysis 2008/2009. Published September 2008.

15 Leif E, Gabriel J; Leif Associates. North Carolina health insurance risk pool: 2009 rating methodology and sample rates. Published June 4, 2008.