Chapter 6

Publicly Funded Insurance Coverage

Public Health Insurance Coverage

Some low-income nonelderly individuals have access to publicly funded insurance coverage through Medicaid or NC Health Choice. However, because of the categorical, income, and resource restrictions, these programs do not cover all low-income, uninsured individuals. In addition, some individuals who are currently eligible are not enrolled. Other low-income individuals are ineligible because of the strict eligibility rules. Because the federal government pays the largest share (63%) of the program costs for Medicaid, the Task Force explored ways to expand this coverage to more low-income, uninsured individuals. The Task Force did not recommend expansions to NC Health Choice to cover more children since the state uses its federal State Children's Health Insurance Program (SCHIP) allotment to cover existing groups of children.

Medicaid

Medicaid is a publicly funded program that provides health insurance coverage to certain low-income individuals and families. To qualify for Medicaid, a person must be the right "type" of person (categorical eligibility) and have income and resources below certain limits. Generally, Medicaid is limited to specified categories of eligible individuals, including pregnant women, children under age 21, families with dependent children, people with disabilities, or older adults (age 65 or older). In addition to categorical requirements, a person must also meet income and, sometimes, resource restrictions (described in Chapter 3). Medicaid income limits vary depending on the program category (e.g., categorical eligibility), and for children, by the age of the child. (see Chart 6.1)

a The NC General Assembly directed the Division of Medical Assistance within the NC Department of Health and Human Services to expand Medicaid to cover working disabled individuals with higher incomes than the existing Medicaid income eligibility guidelines. Individuals will be required to pay a sliding-scale premium based on the amount of their income. N.C.G.S. §108A-54.1. (Effective January 1, 2007 or 30 days after the implementation of the new Medicaid Management Information System).

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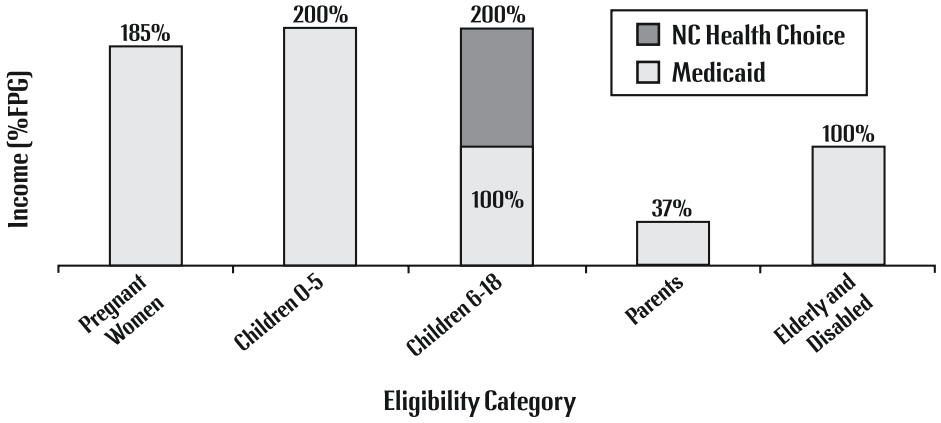
Chart 6.1
Medicaid and NC Health Choice Income Eligibility Standards as Percent of Federal Poverty Guidelines (2005)[a]



For those who qualify, Medicaid offers comprehensive health insurance coverage that is designed to be affordable to low-income people. The covered services include inpatient and outpatient hospital services; physician visits; prescription drugs; diagnostic services; mental health and substance abuse services; physical, speech, and occupational therapy; family planning; and dental, vision, hearing, and long-term care services. Medicaid reimbursement rates are well below the commercial rates, although high in comparison to other states.[1] North Carolina enjoys strong support among the provider community, with many—if not most—providers participating in Medicaid.[b] Medicaid was designed to cover low-income individuals, so federal law restricts allowable cost-sharing to nominal amounts, which are generally no more than $1-$3 for selected services.[c] With the exception of these allowable copayments, providers who participate in the Medicaid program must accept the Medicaid payment as payment-in-full.

Medicaid has helped improve the quality of care provided to Medicaid recipients and has had positive spillover effects on care provided to the uninsured and other people with insurance coverage. In North Carolina, 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.[d] In December 2005, there

b With certain exceptions, providers are not required to accept Medicaid patients. The exceptions include community health centers, Medicare-certified rural health clinics, state-funded rural health centers, health departments, and most hospitals. These providers are required, under state or federal law, to treat Medicaid patients.

c Federal law prohibits cost sharing for certain categories of individuals, including children, pregnant women, and individuals in nursing facilities; and puts limits on the amount of cost sharing for other populations. The law also prohibits states from limiting the services covered for children. For example, states must cover dental care for children even if they choose not to cover dental services for adults (dental is an optional benefit for adults).

d 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, part of which is used to hire case managers to provide education and support services needed to help patients manage their health conditions. Each CCNC network participates in statewide disease management initiatives, based on evidence-based medical practice. In addition, local networks can develop evidence-based systems of care to address local health issues for their Medicaid population.

e The state is in the process of expanding the program to the remaining eight counties.

were 14 regional networks covering approximately 670,000 Medicaid recipients in 92 of 100 counties.[e] The initial results of this initiative have been promising, both in terms of improved clinical care and reduced health expenditures.[2] As a result, in the 2005 Legislative Session, the NC General Assembly instructed the NC Department of Health and Human Services to expand CCNC to dual eligibles (individuals who are receiving Medicaid and Medicare coverage) 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 NC Health Choice beneficiaries have not previously been enrolled in CCNC.

Public Program Options

Outreach and Simplification

Analyses of the Current Population Survey suggest that thousands of nonelderly uninsured people may meet the income eligibility criteria and qualify for Medicaid or NC Health Choice.[f,3] National studies show that many people who are eligible for public programs do not enroll.[4,5] Many of these individuals simply do not know about the programs or the eligibility criteria. Complicated application processes also deter people from applying.

To address this issue, the Task Force suggested that the Division of Medical Assistance (DMA) and the NC General Assembly take steps to increase outreach and simplification efforts to encourage participation by uninsured individuals who are currently eligible to apply for Medicaid. Other states have developed extensive outreach or simplification efforts, for example, by outstationing eligibility workers or creating public information campaigns. Other states have streamlined the eligibility determination process by expanding the eligibility time period from six months to 12 months (37 states),[g] eliminating the need to provide pay stubs or other verification of income (12 states),[h,6] or by eliminating the resource (assets) limits for low-income families (22 states).[i] These expansions would simplify the eligibility process and enable individuals who already qualify for Medicaid to enroll. For example, most low-income families do not have resources that would prevent them from qualifying, so eliminating the asset test would make it easier for the state to provide coverage to greater numbers of qualified individuals. When Louisiana eliminated the assets test for parents, it resulted in an enrollment increase of less than 3%, but the eligibility determination process was greatly simplified.[6]

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f Holmes M. Analysis of US Census. Current Population Survey (CPS) 2002-2004 (Calendar years 2001-2003). Cecil G. Sheps Center for Health Services Research, The University of North Carolina at Chapel Hill. 2005. The analyses show that as many as: 192,000 uninsured children under age 18, 46,000 uninsured adults with dependent children, 13,000 uninsured pregnant women, and 4,000 uninsured people with disabilities may be income eligible for Medicaid or NC Health Choice, but are not enrolled. However, this is likely to be an overestimate of people who are potentially eligible for publicly subsidized health insurance. The CPS typically undercounts people who are eligible for Medicaid. Further, non-citizens, and some individuals that have too many resources, may not qualify even if they meet other program rules.

g Thirty-seven states have implemented 12-month eligibility period for families: AL, AZ, AK, CA, CO, CT, DE, DC, FL, HI, ID, IL, IN, IA, KS, KY, LA, ME, MD, MA, MI, MS, MO, MT, NV, NJ, NY, OR, PA, RI, SC, SD, TN, VA, WV, WI, WY.

h Twelve states have eliminated the need to provide income verification for children's programs (Medicaid or SCHIP): AL, AZ, AK, CT, GA, HI, ID, MD, MI, MT, OK, VT, WY.

i Twenty-two states have eliminated the asset test for parents: AL, AZ, CT, DE, DC, IL, KS, LA, MA, MS, MO, NJ, NM, ND, OH, PA, RI, SC, VT, VA, WI, WY.

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The NC Division of Medical Assistance has already made significant progress in simplifying the application process for children. In addition, the Division recently simplified the adult application form and changed policies to allow mail-in applications. The Task Force applauds the Department's ongoing efforts in this regard, but also identified additional areas to pursue. Based on this information, the Task Force recommends:

Recommendation 6.1: **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.

Recommendation 6.2: **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.

Medicaid Expansion

The Task Force explored different options to expand Medicaid to cover more adults and children. Specifically, the Task Force explored Medicaid expansions to cover:

- Parents with incomes between 37% of the federal poverty guidelines (FPG) (current eligibility limits) and 100% FPG.
- Parents with incomes between 101-150% FPG.
- Parents with incomes between 151-200% FPG.
- Parents with incomes between 201%-300% FPG.
- Children with incomes between 200% FPG (current Medicaid or NC Health Choice eligibility limits) and 300% FPG.

Table 6.1
Covered Services under Medicaid Expansion, Full Medicaid or Medicaid "Light"

Services	Full Medicaid	Medicaid "Light" [j]
Premium	1%-4% individual 2%-8% family	0.5%-2% individual (above 100% FPG) 1%-4% family (above 100% FPG)
Inpatient Hospital (Non-Maternity, Non-Behavioral Health)	Covered (no copay)	Covered: $5,000 deductible/year or $10,000 total; 20% coinsurance ($100 hospital deductible on the $10,000 total package)

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Services	Full Medicaid	Medicaid "Light"[j]
Skilled Nursing	Covered (no copay)	Not covered
Outpatient Hospital Physical Health	Covered (no copay)	Covered, 20% coinsurance, 25 visit limit for physical, occupational, and speech therapy with prior approval by primary care provider (PCP)
Emergency Department	Covered (no copay)	Covered, $100 copay (waived if admitted), 20% coinsurance
Primary Care and Specialty Physician and Non-Physician Clinicians	Covered ($3 copay) (24 visit limit/year)[k]	Covered (sliding-scale primary care copay: $10/$20 for individuals with incomes below/above 150% FPG; specialty copay: $20/$40 for individuals with incomes below/above 150% FPG) 5 physician visit/year (PCP and specialty total)(additional wellness visit allowed, one for adults, according to periodicity schedule for children) Additional visits allowed if actively participating in CCNC and approved by PCP
Pharmacy	Covered, 6 prescriptions/ month limit ($1-$3 copay)	Covered, 6 prescriptions/month limit, waived if actively participating in CCNC case management or disease management (copays: $5 Tier 1, $30 Tier 2, $60 Tier 3)
Well Child Care	Comprehensive coverage for children; No cost sharing for children on any services	Well child visits according to periodicity schedule and immunizations only
Maternity	Covered, no cost sharing	Prenatal care only covered for women if income above 185% FPG. Not covered for dependents (<18 years old) (<185% and dependents covered by Medicaid); delivery charges already covered by Medicaid
Family Planning	Covered, no cost sharing	Contraceptives covered (5 physician visit or wellness visit limit), not included in 6 prescription limit/month
Behavioral Health Inpatient	Covered, excludes state psychiatric hospitals for individuals age 21-64	Covered, 20 day inpatient limit, subject to $5,000 deductible or $10,000 total inpatient coverage limitations (combined with non-behavioral health inpatient limitations)
Behavioral Health Outpatient	Covered, $3 copay for private psychiatrists; priorauthorization required after 8th visit (adults), 26th visit (children)	Covered, 20 day limit (prior authorization after 8th visit for adults). Copay: $20/$40, below/above 150% FPG
Behavioral Health Other for Inpatient with Prior Approval	Covered	Intensive day treatment allowed as substitute
Lab and Radiology Required for MRI and PET Scans	Covered	20% coinsurance, prior authorization

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Table 6.1 continued

Services	Full Medicaid	Medicaid "Light" [j]
Durable Medical Equipment	Covered, no cost sharing (Prosthetics/Orthotics only covered for children < 21)	$500 limit with prior approval (no limit on diabetic supplies)(does not cover glasses)
Case Management	CCNC and case managementfor other selected populations	CCNC only
Home Health and Personal Care Services	Covered, no cost sharing (personal care services limited)	Not covered
Dental	Covered, no cost sharing	Not covered
Podiatry	Covered, 24 visit limit/ year[k]	Covered, 5 physician visit limit/year Copay: $20/$40; below/above 150% FPG
Optometry	Covered, 24 visit limit/ year[k]	Covered, 5 physician visit limit/year Copay: $20/$40; below/above 150% FPG
Ambulance	Covered	$150 copay, waived if admitted; 20% coinsurance
Out-of-Pocket Maximum	None	$2,500 per individual/year on coinsurance
Annual Benefit Limits	None	$1 million/year

The Task Force worked with Mercer Government Human Services Consulting to develop cost estimates for a full Medicaid expansion to these groups with the same comprehensive service package as currently offered through Medicaid, as well as separate estimates for a more limited benefit package (see Table 6.1). The limited benefit package had more comprehensive coverage of preventive services and primary care, but limited coverage of inpatient hospitalizations. Mercer provided cost estimates for two different versions of the limited benefit package: one with a $5,000 hospital deductible and another with $10,000 total hospitalization coverage.

The Medicaid "light" package does not include nursing home care, home health services, personal care services, dental, or prenatal care for pregnant women with incomes below 185% FPG, which are already covered under traditional Medicaid. The Task Force also considered other options to reduce the costs of a limited benefit package, but funds were unavailable to obtain full actuarial estimates of these changes.[j]

j The Task Force considered additional restrictions in coverage if needed to further reduce the cost of the Medicaid expansion, however, funds were not available to develop cost estimates to determine the amount of savings that could be achieved through these benefit reductions. Some of the options that the Task Force considered included a maximum coverage limit of $10,000 on outpatient hospital services. This limit would apply to outpatient surgery, diagnostic imaging, and other outpatient services, but would not apply to emergency services, chemotherapy, or radiation therapy. Other options the Task Force considered included limiting prescription drug coverage to two prescriptions/month (contraceptives would not be subject to the two prescriptions/ month limit; and the limit could be waived if actively participating in CCNC). The Task Force also considered requiring prior authorization for outpatient behavioral health services for adults after the eighth visit; limiting inpatient behavioral health services to 20 days of coverage, and allowing individuals to substitute intensive day treatment for inpatient behavioral health services (with prior authorization). The Task Force members also suggested providing a 10% discount for nonsmokers or people actively participating in a smoking cessation course, but this discount was not included in the cost estimates provided herein.

k Medicaid visits to primary care and specialty physician and non-physician clinicians, podiatrists, and optometrists, combined, are subject to a total 24-visit annual limit.

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Table 6.2
Expected Participation Rates for Low-Income Families in Insurance Expansion, by Premium Cost

	EXPECTED PARTICIPATION RATES		
Individual Premium Cost	**<150% FPL**	**150-250% FPL**	**≥ 250% FPL**
Free	74%	79%	86%
$1	49%	56%	63%
<2% income	36%	43%	52%
2-6% income	25%	33%	39%
6-10% income	20%	28%	32%
10-14% income	16%	19%	24%
14-20% income	11%	16%	20%
20+ income	8%	11%	14%
Family Premium Cost	**<150% FPL**	**150-250% FPL**	**≥ 250% FPL**
Free	82%	88%	95%
$1	70%	80%	90%
<2% income	60%	72%	86%
2-6% income	50%	65%	78%
6-10% income	40%	55%	62%
10-14% income	32%	38%	47%
14-20% income	22%	31%	39%
20+ income	15%	22%	28%

Source: Feder, Ucello, O'Brien. The Difference Different Approaches Make: Comparing Proposals to Expand Health Insurance. The Kaiser Project on Incremental Health Reform, Kaiser Family Foundation. October 1999.

Individuals in a Medicaid expansion program would be required to contribute toward the costs of coverage, using a sliding-scale premium based on family income. The premium included for the full Medicaid package was higher than that for the more limited Medicaid package, reflecting the more comprehensive coverage and the higher costs. Past studies suggest that lower-income people are less able to pay health insurance premiums, even when set at a percentage of the family's income.[7] Thus, the Task Force designed a premium structure, with no premium for individuals with incomes below 100% FPG, and phasing up to 2% for those with incomes up to 200% (see Table 6.2). Mercer Government Human Services Consulting estimated that the premium structure would result in a 50% enrollment rate for the full Medicaid coverage and a 30% enrollment rate for the limited benefit package (see Appendix E).

If the state were to expand full Medicaid to cover all children and parents with incomes below 300% FPG, it would cover approximately 174,000 people at a cost of $354.5 million to the state and counties (see Table 6.3). The federal government would contribute $603.5 million. Expanding Medicaid to all children and parents with incomes below 300% FPG with a more limited benefit package (including $10,000 total hospital inpatient coverage) would extend coverage to approximately 104,000 people for a cost to the state and counties of $121.3 million and $206.6 million to the federal government.

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Table 6.3
Medicaid Expansion Costs and Covered Lives, FY 2006 (in millions)[l]

	PARENTS[m]				CHILDREN	TOTAL
	37% to 100% FPG	101% to 150% FPG	151% to 200% FPG	200% to 300% FPG	200% to 300% FPG	Total
Full Medicaid						
Avg. Covered Lives	62,810	37,359	29,679	23,991	19,728	173,566
State Share	**$125.3**	**$71.0**	**$52.8**	**$37.1**	**$15.7**	**$301.8**
County Share	**$21.9**	**$12.4**	**$9.2**	**$6.5**	**$2.7**	**$52.7**
Federal Share	$250.6	$141.9	$105.5	$74.1	$31.3	$603.5
Member premium	$0	$5.5	$12.2	$24.7	$11.3	$53.6
Member out-of-pocket	$3.1	$1.8	$1.4	$1.1	$0.6	$8.0
Limited Benefit $5,000 Hospital In Patient Maximum						
Avg. Covered Lives	37,686	22,415	17,807	14,394	11,837	104,139
State Share	**$41.6**	**$23.6**	**$17.4**	**$12.3**	**$5.2**	**$100.1**
County Share	**$7.3**	**$4.1**	**$3.0**	**$2.1**	**$0.9**	**$17.5**
Federal Share	$83.2	$47.3	$34.7	$24.6	$10.5	$200.2
Member premium	$0	$1.6	$3.7	$7.4	$3.4	$16.1
Member out-of-pocket[n]	$50.7	$29.4	$24.0	$19.0	$9.8	$132.9
Limited Benefit $10,000 In Patient Maximum						
Avg. Covered Lives	37,686	22,415	17,807	14,394	11,837	104,139
State Share	**$42.8**	**$24.4**	**$17.9**	**$12.8**	**$5.4**	**$103.3**
County Share	**$7.5**	**$4.3**	**$3.1**	**$2.2**	**$0.9**	**$18.0**
Federal Share	$85.7	$48.7	$35.8	$25.5	$10.9	$206.6
Member premium	$0	$1.6	$3.7	$7.4	$3.4	$16.1
Member out-of-pocket	$42.0	$24.4	$20.1	$15.9	$7.1	$109.4

Priority Expansion for Low-Income Parents

North Carolina's income eligibility rules are comparable to or higher than many other states for pregnant women, children, older adults, and people with disabilities. However, North Carolina's income eligibility rules for parents are among the lowest in the country.[o,8] North Carolina limits Medicaid to working adults with a net countable family income of less than approximately 37% FPG (or approximately 57% when considering gross income). Only 15 states have lower income eligibility limits for parents than North Carolina. As a result, the Task Force's top priority for Medicaid expansion is to cover parents and pregnant women with incomes up to 200% FPG with a limited benefits package.

l The costs in Table 6.3 include the cost of covered services only, not the state or county administrative costs in determining eligibility.

m The cost estimates do not include the additional costs of covering first-time pregnant women with incomes between 185-200% FPG.

n Approximately 21% of the members' out-of-pocket costs are attributable to the $5,000 hospital deductible.

o Only 15 states have lower income eligibility limits for parents than North Carolina: AL (19%), AR (20%), CO (39%), ID (31%), IN (29%), KS (38%), LA (20%), MD (40%), MS (35%), NE (56%), NJ (41%), OK (45%), TX (33%), VA (36%), WV (38%).

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The Task Force recommends that the limited benefit package be focused on ambulatory care, with incentives to actively participate in disease and case management services when appropriate. Inpatient hospital services would be limited to $10,000 total coverage annually.[p] Expanding Medicaid was considered one of the most cost-effective ways to provide coverage to the uninsured, since the federal government pays 63% of program costs. Further, this expansion would not be an entitlement, so the state could limit the number of people who would be covered under this option.

The primary beneficiaries of this expansion would be working adults who either are not offered health insurance through their jobs or are making wages so low they have difficulty affording coverage that may be offered. However, children also stand to benefit, as studies show that children are more likely to have health insurance coverage and to receive medical services if their parents are also covered.[9] For approximately $100 million (in state and county funds), North Carolina could expand Medicaid to cover approximately 78,000 adults. The federal government would contribute $170 million. The state would need to seek a waiver of traditional Medicaid rules in order to offer a more limited Medicaid benefit package that emphasizes primary care with limited hospital coverage and more extensive cost sharing.[q] These uninsured adults would be required to pay premiums, on a sliding-fee scale basis, along with other cost-sharing that would incentivize them to become more prudent purchasers of care. Under the Task Force's plan, members would be required to pay approximately $5.3 million in premiums and approximately $86.5 million in out-of-pocket costs (not including any amount in excess of the $10,000 hospital inpatient coverage). Enrolled individuals will be encouraged, and given the information and support needed, to better manage their own healthcare. The Medicaid expansion would also be combined with a premium assistance program to help pay the employees' premium costs for private insurance, when cost effective to the state to do so. In addition, the group feels that the state should cover the county share of service and administrative costs to avoid undue financial burden on county governments.

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p The Task Force members decided to recommend a limited benefit package with $10,000 total hospital inpatient coverage. For many individuals, this would actually provide better coverage. Many individuals have inpatient stays that cost less than $10,000. For those who do exceed the $10,000 limit, many hospitals will write-off these costs (for people below 200% FPG). In addition, hospitals have an incentive to write-off any amount above $10,000 in order to qualify for coverage under the Medicaid Disproportionate Share Hospital (DSH) payment system. Under DSH, hospitals can receive additional Medicaid payments to help offset some (but not all) of the charity care provided to uninsured individuals. Bad debt does not qualify for DSH reimbursement, thus a hospital may not be able to receive DSH payments for uncollected charges if it tries to collect the amount in excess of $10,000.

q North Carolina would need to seek a Section 1115 waiver or Health Insurance Flexibility and Accountability (HIFA) waiver to be able to offer a limited Medicaid benefit package with premiums and more substantial cost-sharing42 U.S.C. §1315. The US Department of Health and Human Services, Centers for Medicare and Medicaid Services, administers Section 1115 and HIFA waivers. Available at: http://www.cms.hhs.gov/hifa/default.asp. Accessed December 5, 2005.

Recommendation 6.3: 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% FPG with a limited benefits package.

a) The NC General Assembly should direct the NC Division of Medical Assistance to seek an 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 hospitalizations.

   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 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 premiums, if cost effective to the state.

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

Recommendation 6.4: 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 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.

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r This analysis is based on BlueCross BlueShield of North Carolina's Blue Advantage plan.

Private-Public Partnerships

High-Risk Pool

BlueCross BlueShield of North Carolina (BCBSNC) is the only insurer in the state to offer health insurance in the nongroup market on a guaranteed issue basis.[r] Premiums vary, based on the age, geographic location, and health status of the individual. Individuals are placed into one of seven premium tiers, depending on their health status. Those in the highest four tiers are currently paying more than 150% of the standard rate charged to healthier individuals. In fact, individuals in the highest-risk category may be paying up to 700% of the standard rate. For example, nongroup health insurance coverage for a 35-year-old male with major health problems could cost more than $800/month (for $1,000 deductible, 30% coinsurance plan), or more than $1,800/month for a 55-year-old male. People with pre-existing health problems are most in need of health insurance to help pay for healthcare services, but the premiums needed to cover the costs of care make this coverage unaffordable.

Thirty-three states have established high-risk pools to help spread the costs of providing insurance to people with significant pre-existing health problems.[10] Two bills were introduced in the 2005 NC Legislative Session to create high-risk pools (HB 1535, SB 534), and another bill was introduced to create a study commission to examine this issue (HB 180). Research suggests that about 1% of North Carolina's population is medically uninsurable,[11] and only about 10% of these individuals would enroll. States limit the maximum premium charged to medically uninsurable individuals to make it more affordable, and some states provide a further subsidy to help lower-income individuals pay the premiums. The premiums paid do not cover the full cost of the claims incurred in these high-risk pools. Therefore, most states fund the deficits either through an assessment on the insurance companies, state appropriations, or other means.

Congress appropriated $90 million in grant funds to be distributed to the states as part of the Deficit Reduction Act of 2005 to help states offset losses incurred in qualified high-risk pools.[12] Fifteen million dollars were set aside in federal fiscal year 2006 to provide start-up funds of up to one million dollars for states that have not yet established a high-risk pool. The legislation also appropriated $75 million/year through 2010 to help offset up to half of the ongoing operational costs of state high-risk pools: 40% of the money will be distributed equally among states that operate high-risk pools, 30% based on the numbers of uninsured, and 30% based on the number of participants in the high-risk pool.

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s Twenty-seven states use an assessment on insurers to help fund the losses in the high-risk pool. Of this, 11 states provide full or partial tax credit offsets for the assessment, thereby shifting the costs back to the state (AL, AR, IN, IA, KS, MO, MT, NM, ND, SC, WY); another 11 states have no tax credit offset (AL, CT, FL, ID, IL for its HIPAA pool, KY (partial funding source), LA (only for its HIPAA pool), MN, OK, TX, WA). Seven of the states have a broad assessments on insurers, including commercial insurance carriers, stop-loss, reinsurance carriers, and Third Party Administrators (TPA's) on a per-person/per-month basis (CO, IN, MS, NH, OR, SD, and WA). Two states pay for the high-risk pool through surcharge on hospital bills (MD, WV) and six states use general revenue or other sources of funding (CA, IL, KY, LA, NE, UT).

t Seven states help subsidize the premium costs for lower-income individuals (CO, CT, MT, NM, OR, WA, WI).

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The Task Force recommends creating a high-risk pool that limits premiums to 150% of the standard risk, so that more of the people with pre-existing health problems could afford coverage. Losses would be covered through an assessment on insurers, including traditional insurance companies, Health Maintenance Organizations (HMOs), Multiple Employer Welfare Arrangements (MEWAs), third party administrators, stop-loss, and reinsurance carriers.[s,10] Providers would be paid using the Medicare payment rates, which is less than what is typically offered through commercial insurance. The NC General Assembly should also help subsidize the premium costs for lower-income individuals.[t]

Task Force members also recommended that the high-risk pool provide guaranteed coverage to HIPAA-eligible individuals in the nongroup market. These are individuals who were previously insured for at least 18 months and who have exhausted their Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage (if available). Twenty-seven other states use their high-risk pools to ensure guaranteed coverage for these individuals.[13] A study by the General Accounting Office (GAO) found that states that used their high-risk pool to ensure portability of coverage to individuals in the nongroup market after exhausting COBRA coverage offered lower rates than other states that did not have this protection.[14] Fifteen states also used their state high-risk health insurance pool to provide coverage to individuals who lost health insurance under the Trade Adjustment Act, through the Health Coverage Tax Credit program (HCTC).[13] Individuals eligible for coverage under HCTC can receive a refundable tax credit equal to 65% of the premium paid by the individual and qualifying family members. The Task Force recommends that the high-risk pool be used to provide coverage to these individuals, but that federal funds be used to subsidize the coverage before state premium subsidies are used.

In order to discourage people from waiting until they have large healthcare expenses before enrolling in the high-risk pool, the Task Force recommends that individuals who enroll without prior creditable coverage be subject to a preexisting condition exclusion of up to 12 months. However, the Task Force did not want to penalize those individuals who, as of the date that the pool first becomes operational, are high-risk, uninsured, and meet all eligibility criteria for the pool, by subjecting them to a 12-month exclusion for their pre-existing conditions. These individuals would not have had an affordable coverage option available to them when they first became uninsured. On the other hand, the Task Force recognized that the pool could immediately be faced with relatively high claims cost upon the initial enrollment of this group if they were not subject to any waiting period at all for their pre-existing conditions. As a compromise, the Task Force recommends that the high-risk pool include an open enrollment period when it first becomes operational, to allow individuals who did not previously have access to affordable coverage to enroll in the high-risk pool with a reduced exclusionary period of six months.

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u Recognizing that many individuals decline coverage due to high premium costs in Tiers 4-7, BCBSNC used the distribution of applicants for Blue Advantage for its base population estimates, rather than actual enrollees in Tiers 4-7. After determining the distribution of individuals who would fall into each of the top four tiers, BCBSNC calculated total cost projections for a high-risk pool based on the actual experience of claims costs in Tiers 4-7. These cost estimates were based on an average Blue Advantage benefit design, which is roughly equivalent to a $1,500 deductible, $25 copay, and 75% coinsurance.

BCBSNC conducted an analysis using its member claims data for the high-risk tiers (e.g., those individuals currently paying more than 150% of the standard rate).[u] Based on North Carolina data and experience, BCBSNC estimates that it would cost approximately $30 million per year, in addition to the premiums paid by the customers, to operate a high-risk pool in North Carolina. The estimates assume that 9,000 medically uninsurable people would enroll in the high-risk pool, or about 10% of the eligible population. The estimates also assume a population risk profile that closely resembles Blue Advantage applicants, healthcare utilization that is similar to those who are currently enrolled in Blue Advantage, an administrative cost to run the pool of 7.5% of claims, and provider payments based on the Medicare rates.[v] Some of these costs may be subsidized if Congress passes legislation to help subsidize state high-risk pools.

There would likely be a greater number of enrollees if the state provides an additional premium subsidy for low-income people. Data from other states suggest that enrollment could be higher (between 10-30%) if the state provides an additional subsidy to help reduce premium costs.[10] The Task Force assumed 20% participation (or 18,000 enrollees) if the state provided an additional premium subsidy.

Specifically, the Task Force recommends:

Recommendation 6.5: 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 or Medicare 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

v BlueCross BlueShield of North Carolina estimated that the high-risk pool would cost $40 million assuming that BCBSNC paid the rates generally paid through its Preferred Provider Organization (PPO) products. Using Medicare reimbursement rates would lead to a reduction in overall costs to approximately $30 million. FitzSimon C. Personal communication. November 15, 2005.

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 premiums.

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 reimbursements 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.

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