Chapter 7  Conclusion

North Carolina is in the midst of a healthcare crisis it cannot afford to ignore. More than 1.3 million nonelderly North Carolinians lacked health insurance coverage in 2004, or more than one sixth of the state's nonelderly population. Compared to most other states, North Carolina is experiencing a more rapid increase in the percentage of people without health insurance coverage and a more rapid decline in the percentage of people with employer-sponsored insurance.

The increased cost of health insurance premiums is the primary cause for the rise in the numbers of uninsured nationally and in North Carolina.[1] More than half (55%) of the uninsured in North Carolina reported that they were uninsured because health insurance was too expensive.[2] The average cost of employer-sponsored insurance (ESI) in North Carolina was more than $3,200 per year for an employee or $8,200 for family coverage in 2002-2003. Nationally, between 2000 and 2004, ESI premiums increased by 65%, much faster than the increase in general inflation (9.7%) or wage growth (12.2%).[3] As a consequence, health insurance coverage is becoming unaffordable for businesses to offer to their employees and for individuals to purchase.

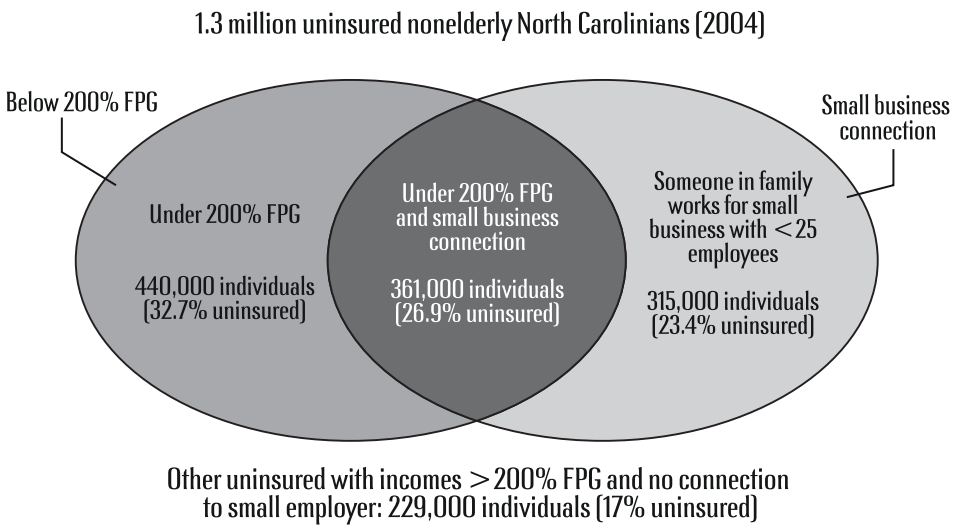
Health insurance premiums are rising because of the increase in underlying healthcare costs. There are many reasons for this increase, including that people are using more services, costs of services are increasing, and overall disease prevalence is rising. Many lifestyle choices and lifestyle-related illnesses increase the risk of chronic diseases, which leads to rising healthcare costs.

Many people are unable to afford healthcare coverage because of these increased costs. Two groups are the most likely to lack health insurance coverage: those who have a connection to a small firm and individuals with family incomes below 200% of the federal poverty guidlines (FPG) (see Chart 7.1). In fact, half (50%) of the uninsured are workers or family[a] of workers in a small firm. Three fifths (60%) of the uninsured have low incomes, (income below 200% FPG). In total, more than four fifths (83%) of the uninsured fall into one of these two groups. Individuals with pre-existing health problems also have a greater risk of being uninsured.

a *Family*, as used in Current Population Survey analyses throughout this report, is broadly defined and includes more individuals than those typically eligible for dependent health insurance coverage. A more conservative analysis suggests that one third of the uninsured are either employees or dependents of employees of a small firm. See Appendix F for more details.

Chapter 7  Conclusion

Chart 7.1
Uninsured in North Carolina: Primarily Low Income or Employees of Small Firms



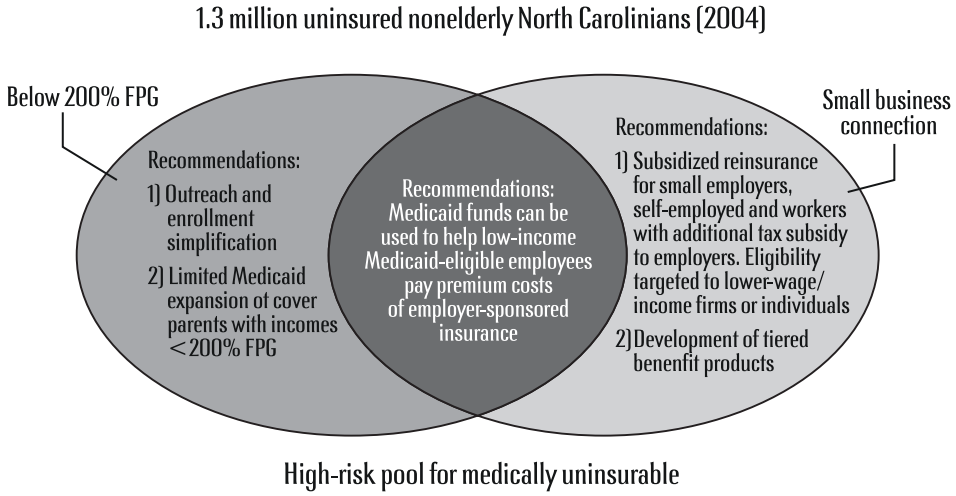
People who are uninsured have more difficulty obtaining needed health services than those with insurance coverage. Uninsured North Carolinians are less likely to have a regular doctor or get preventive health services.[4] They are more than four times more likely than people with insurance to report that there were times in the last 12 months when they needed to see a doctor but couldn't because of costs. In general, the uninsured use fewer services and delay care, which makes them more likely to be diagnosed with a serious health condition—such as late stage cancer—or be hospitalized for conditions that could have been prevented if they received adequate primary care. Further, lack of insurance coverage and uncovered healthcare costs are a major contributor to personal bankruptcies.

Not only does lack of insurance coverage affect individuals and families without insurance coverage—it affects everyone. People in poor health are less likely to work or may work fewer hours. Children who are sick have a harder time learning in school. The cost of providing care to the uninsured is also shifted to those with private health insurance coverage, leading to higher health insurance premiums in the private market. One study suggests that the increased cost of caring for the uninsured in North Carolina has led to an increase in employer-sponsored insurance—$438 per year for individuals and $1,130 for families. In addition, the growing numbers of uninsured are creating an economic strain on the healthcare institutions that care for everyone.

The NC Institute of Medicine (NC IOM) Task Force on Covering the Uninsured focused its work on expanding health insurance coverage to the two groups most likely to lack coverage—small employers, low-income families—and to those with pre-existing health conditions. The recommendations concentrate in three areas: (1) subsidies and new insurance products aimed at making health insurance more affordable to small employers, (2) a Medicaid limited benefit package for low-income adults, and (3) a high-risk pool for people with pre-existing health problems. (see Chart 7.2)

Chapter 7  Conclusion

Chart 7.2
Uninsured in North Carolina: Covering the Uninsured Task Force Primary Recommendations



The Task Force tried to balance the need to provide health insurance to more uninsured with the necessity to restrain new health spending for employers, uninsured individuals and families, and government. Thus, many of the recommendations include limited benefit packages and/or cost sharing to ensure that, to the extent possible, uninsured individuals and families contribute toward the cost of their own care. The Task Force recommendations also encourage people to become active stewards of their own care. The recommendations include proposals to enroll individuals with complex or chronic health conditions into disease and/or case management programs, reward individuals for healthy lifestyles, and encourage the use of preventive health services.

The Task Force recognized that every group, including families, healthcare providers and institutions, employers, insurers and agents, and government, stands to gain by expanding health insurance coverage to the uninsured. Everyone will benefit from a healthier and more productive workforce and fewer medically-related bankruptcies. As more people gain insurance coverage, there will be less uncompensated care. This, in turn, will decrease the need to shift the uncompensated costs of serving the uninsured onto people with insurance coverage. This should help moderate rising healthcare costs for those with insurance.

Just as each group stands to gain by expanding insurance coverage to the uninsured, there is a shared responsibility to contribute to the solution. Individuals should purchase healthcare coverage when affordable coverage is available. Employers can help by offering and paying for part of their employees' insurance costs. Insurers can assist by creating lower-cost products and helping subsidize some of the costs of care for high-risk individuals. Agents can help by marketing new products to small employers and uninsured individuals. Providers can help by accepting lower reimbursement rates for individuals who were previously uninsured. Government can play a role by helping to subsidize the costs of insurance for those who have low incomes.

Chapter 7  Conclusion

The NC IOM Task Force on Covering the Uninsured spent almost a year studying this issue, and developed 13 recommendations that could significantly increase the availability of affordable coverage to the uninsured. The recommendations are listed below, along with the groups (families, businesses, providers, insurers, or government) that are being asked to assist in implementing or financing the recommendation. Additional information about each recommendation is included within the chapters noted in the table. The table below also includes estimates of the number of people who will be covered by the proposal, as well as preliminary cost estimates of the different recommendations when fully implemented (when such data are available). A description of the source of the estimates as well as the methodology used to determine the estimates are included in the footnotes. These cost estimates assume full implementation, which will take several years to achieve. Recommendations the Task Force considers priority are indicated in the table by shading.

Recommendations

Chapter 1: Introduction

Rec. 1.1: The NC General Assembly should help support and expand the existing healthcare safety net to be able to meet more of the healthcare needs of the uninsured.

Role and Responsibility:

- Providers (provide care to the uninsured) and
- Government (NC General Assembly appropriate funding to support and expand safety net)

Chapter 4: Trends in Healthcare Costs

Rec. 4.1:

a) Individuals have a responsibility to understand their health needs and risks and to be better stewards of their own health. To promote healthy lifestyles:
   i) Individuals should be given the education, support, and resources needed to make informed healthy lifestyle choices, and they should use these resources to make healthy choices.
   ii) Individuals with chronic diseases should be provided information and access to health services in order to manage their health conditions in a manner consistent with best known evidence-based care.
   iii) Individuals who engage in risky health behaviors (such as smoking, sedentary lifestyles, or abuse of drugs or alcohol) should be expected to pay differential premiums to cover some of the increased healthcare costs of their unhealthy lifestyle choices.

b) Providers, employers, insurers, schools, and government should work together to promote healthy lifestyle choices and encourage people to participate in evidence-based wellness initiatives.
   i) Insurers should develop insurance products with financial incentives that reward healthy lifestyle behaviors and should cover wellness-related services (such as smoking cessation) as a basic benefit.
   ii) Providers should educate individual patients and, where appropriate, their family members, about the importance of lifestyle choices in maintaining optimal health; provide information and referrals to help patients engage in healthy behaviors; and provide patients with the information and skills needed to manage chronic disease conditions.
   iii) Employers should, to the extent possible, establish policies and environments that support positive behaviors (i.e., access to healthy food in vending machines and cafeterias, ensuring a tobacco-free environment, encouraging activity at work) and offer wellness programs to engage employees in health awareness and improvement programs in the workplace.

iv) Schools should also establish healthful policies and environments, including healthy food in cafeterias; opportunities for all youth to be active daily at school; tobacco-free policies; and educational opportunities to teach students the importance of healthy lifestyles to maintain optimal health.

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

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

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

Role and Responsibility:

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

Rec. 4.2: The NC General Assembly should create a study commission to identify other ways to reduce the growth in healthcare costs to lower overall costs for private and public healthcare plans.

Role and Responsibility:

- Government: The NC General Assembly should fund a legislative commission to study this issue.

Chapter 5: Private Options to Expand Health Insurance Coverage

Rec. 5.1: The NC General Assembly should enact a Healthy North Carolina program, targeted to low income, uninsured, working individuals, employers of firms with 25 or fewer employees, and self-employed/ independent contractors, which offers more affordable health insurance products than what are currently available in the North Carolina marketplace. The health insurance benefits and associated cost-sharing should be closely aligned with current small-group products, with the inclusion of coverage for mental health and prescription drugs

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

i) Employer eligibility is limited to employers with 25 or fewer employees that have not provided group coverage for employees within the last 12 months. At least 30% of the employees must be low income (defined as having an hourly wage of $12 or less, indexed annually by the Medical Component of the Consumer Price Index). To qualify, at least 75% of the eligible employees who do not have other health insurance coverage must elect coverage under this plan. Qualified employers must contribute at least 50% of the premium cost for individual coverage. Qualified employers should receive an additional tax credit to help subsidize some of the premium costs paid in excess of 50% of the premium costs for the individual if: the employer contributes more than 50% of the premium cost for individual coverage, the employer contributes toward the cost of dependent coverage, or the employer has greater than a 75% participation rate among employees who do not have other coverage.

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

Recommendations continued

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

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

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

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

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

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

Estimated uninsured covered: 33,500

Role and Responsibility:

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

Rec. 5.2: The NC General Assembly should authorize and fund a study, to be conducted by the NC Department of Insurance, of the impact of small-group reform in North Carolina and potential reforms to the existing small-group reform laws that may increase healthcare coverage among small employer groups.

a) The study shall consider whether changes to any element of North Carolina's current small-group rating system, to the definition of small employers, or to how rating requirements apply to small employers of different sizes could be expected to result in increased coverage among small employers. In evaluating these questions, the experiences of other states' small-group rating systems should be considered.

b) The NC Department of Insurance should convene a group that includes representatives of small business, brokers, underwriters, and other experts who can review the data and determine whether changes are needed to existing small-group reform laws.

c) Funding for this study would enable the Department to secure data and expertise from consultants that otherwise would not be available to the Agency.

Role and Responsibility:

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

Rec. 5.3:

a) The NC Institute of Medicine Covering the Uninsured Task Force supports the work of the NC Health Insurance Innovations Commission, whose statutory mandate is to investigate the problems small employers face when trying to purchase health insurance coverage and to initiate regional demonstration projects to pilot innovative health plans.

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

Role and Responsibility:

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

Rec. 5.4: Private insurance companies should develop and sell tiered benefit packages that offer low-cost health insurance products in North Carolina. The lowest-cost tier should offer basic healthcare coverage, which can be enhanced to include more comprehensive benefits with reduced cost sharing and higher premiums.

Estimated uninsured covered: 27,500

Role and Responsibility:

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

Rec. 5.5: The NC General Assembly should provide the NC Department of Insurance authority and guidelines to apply state-mandated benefit laws in a flexible manner in instances where strict application of such laws would preclude the approval of tiered health insurance benefit plans, or it should enact a law regarding the application of mandated benefits that would have a similar effect.

Role and Responsibility:

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

Chapter 7  Conclusion

Recommendations continued

Chapter 6: Public Options

Rec. 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.

Estimated new eligibles: 25,500 [c] See methodology explanation at the end of the table.

Role and Responsibility:

- Government: The Division of Medical Assistance should further work to simplify the application process and do more outreach to encourage eligible individuals to apply for and maintain coverage. [c] (Estimated costs based on 10% of potential eligibles enrolling. State costs: $29.2 million, county costs: $5.2 million, federal costs: $59.5 million)

Rec. 6.2: 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.

New eligibles included in estimates for 6.1

Role and Responsibility:

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

Rec. 6.3: 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% of the federal poverty guidelines (FPG) with a limited benefits package.

a) The NC General Assembly should direct the NC Division of Medical Assistance to seek a 1115 waiver to develop a limited benefit package. As part of the 1115 waiver, the NC General Assembly should:
   i) Charge a sliding-fee scale premium that is based on the family's income, ranging from 0.5% for individuals with incomes equal to 100% of the federal poverty guidelines to 2% for individuals with incomes at 200% of the federal poverty guidelines. Nonsmokers or individuals who are actively participating in smoking cessation programs would be entitled to a 10% reduction on their premiums.
   ii) Develop a limited benefit package that focuses on primary care and provides $10,000 in coverage annually for inpatient hospitalization.
   iii) Include copayments and coinsurance in the benefits package on a sliding-scale basis that encourages the use of more cost effective health interventions.
   iv) Enroll participants in Community Care of North Carolina (CCNC) and provide incentives to actively participate in disease and case management.
   v) Implement a voluntary premium assistance program, so that low-income individuals with access to employer-sponsored insurance can use Medicaid funds to pay for their share of the premium, if cost effective to the state.

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

Estimated new eligibles: 78,000

Role and Responsibility:

- Families: Families should enroll, pay premiums and cost sharing, and participate in disease management. (estimated costs: $5.3 million in premium costs, $86.5 million out-of-pocket cost sharing, not including any amount in excess of the $10,000 hospital inpatient coverage). [d] See methodology explanation at the end of the table.
- Providers: Providers will accept Medicaid rates, which are lower than commercial rates; some of the $86.5 million in cost sharing will be absorbed by providers. [d]
- Government: The NC General Assembly will appropriate funds to cover state and county share of Medicaid expansion. The NC Division of Medical Assistance should seek a waiver from the US Centers for Medicare and Medicaid Services to offer a limited benefit package. (estimated costs: $100 million in state/county costs, $170.2 million federal). [d]

Rec. 6.4: 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 (CCNC) networks to:

a) Determine the health risks of the Medicaid population.

b) Identify priorities for wellness initiatives.

c) Assess the costs of implementing a HRA program statewide or with targeted eligibility groups.

d) Assess the potential cost savings from targeted wellness initiatives.

Role and Responsibility:

- Families: Individual enrollees will participate in wellness initiatives.
- Providers: Providers will participate in wellness initiative as part of CCNC network.
- Government: Division of Medical Assistance will develop and administer the wellness initiative through CCNC.

Rec. 6.5: 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, Medicare, or COBRA coverage, and
   ii) Are unable to purchase a policy except with a premium that is higher than that offered through the pool or have been rejected by a commercial insurer due to pre-existing health problems.

b) Individuals who enroll in the high-risk pool shall be subject to a pre-existing condition exclusionary period of up to 12 months unless the individual had creditable prior coverage, in accordance with NCGS §58-68-20(c) .
   i) The NC General Assembly should create an open-enrollment period of six months when the program first becomes operational to allow individuals to enroll in the program with a reduced pre-existing condition exclusionary period of six months.

c) Premiums should be limited to 150% of the standard risk rate.
   i) The state should provide an additional subsidy to help individuals with incomes below 300% of the federal poverty guidelines pay for their share of the premium. The state subsidy would pay for 95% of the premium costs for individuals with incomes below 100% of the federal poverty guidelines to be phased out when a family's income reaches 300% of the federal poverty guidelines. The subsidy would be based on the lowest cost plan offered through the high-risk pool. Individuals who are eligible for a federal premium subsidy under the Trade Adjustment Act must apply for such coverage. The amount of the state subsidy will be reduced by any federal premium subsidy provided.

Recommendations continued

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

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

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

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

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

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

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

i) Premiums and other cost sharing for covered individuals.

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

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

iv) Provider reimbursement limited to the Medicare reimbursement rates.

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

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

Role and Responsibility:

- Families: People with pre-existing conditions should enroll and pay premiums and other out-of-pocket costs. (estimated costs: $32.4 million in premiums (assuming 9,000 enrollees and no additional premium subsidy. The costs to the families do not include other out-of-pocket costs, including deductible, copayments, or coinsurance). If an additional premium subsidy were provided, we assume 18,000 enrollees. Families would pay $31.6 million in premium costs (not including other out-of-pocket costs). The state would pay the additional premium costs).[e] See methodology explanation at the end of the table.
- Providers: Providers should accept Medicare rates in lieu of regular commercial rates. [estimated costs: $10 million (assuming 9,000 enrollees) or $20 million (assuming 18,000 enrollees)]. [e]
- Insurance: Insurers will be assessed to create a high-risk pool [estimated costs: $30 million (assuming 9,000 enrollees) or $60 million (assuming 18,000 enrollees)]. [e]
- Government: The state government would pay $33.2 million to help subsidize the premium costs for lower-income individuals with pre-existing conditions. [e]

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

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

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

[d] Mercer Government Human Services Consulting. The cost estimates were based on expanding Medicaid with a limited benefit package to parents up to 200% of the federal poverty guidelines (FPG). It did not include the costs of covering first-time pregnant women with incomes between 185-200% FPG, as this recommendation was included later in the Task Force's deliberations. The

estimates assume a 30% take-up rate among those potentially eligible for the limited benefit package. The estimates were adjusted for pent-up demand, anti-selection factors, potential health status of participants, and benefit package design. Cost estimates are trended forward to CY 2006. Estimates do not include state or county administrative costs. The Task Force recognizes that some of the out-of-pocket costs will be paid by the families and some will be absorbed by the providers as uncompensated care.

[e] BlueCross BlueShield of North Carolina (BCBSNC) estimated that the high-risk pool would cover approximately 18,000 people (approximately 20% of medically uninsurable), with losses to the pool of roughly $40 million in addition to premiums paid (of $32.4 million) This estimate was based on BCBSNC data and experience, assuming a risk profile that resembled Blue Advantage applicants, healthcare utilization similar to those who are currently enrolled in Blue Advantage, and an administrative cost to run the pool of 7.5% of claims. The estimate assumes the Blue Advantage benefit design, which is roughly equivalent to a $1,500 deductible, $25 copay, and 75% coinsurance, and BCBSNC's Preferred Provider Organization (PPO) provider reimbursement rates. Reducing provider reimbursement in the high-risk pool to Medicare rates would provide additional savings of approximately 15%, so the total losses to the pool would be $30 million. If an additional premium subsidy were provided and 18,000 people enrolled, the losses to the pool would equal $60 million.[8]

Experience from other states suggests that enrollment could be higher (between 10-30%) if the state provides an additional subsidy to help reduce the premium costs. The Task Force assumed 20% participation if the state further helped subsidize the premiums. The state subsidy estimates assume 18,000 enrollees. The percent of the state high-risk pool enrollees in each poverty category are estimated by the distribution of uninsured who specify their health as fair or poor in CPS 2003-2004. Then a sliding-scale premium subsidy was applied based on the family's income. Fourteen percent of those in fair or poor health had incomes below 100% FPG (95% subsidy), 39% had incomes between 100-200% FPG (75% subsidy), 35% had incomes between 200-300% FPG (25% subsidy), and 12% had incomes in excess of 12% (0% subsidy). If an additional premium were provided similar to these given assumptions, the enrollees would pay approximately $31.6 million, and the state would pay approximately $33.2 million.[8]

Chapter 7  Conclusion

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