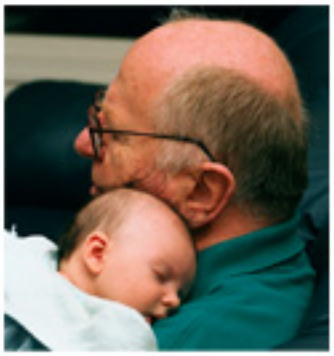
NC Health Choice: 2003

Report of the North Carolina Institute of Medicine Task Force on the NC Health Choice Program

Submitted to the North Carolina Department of Health and Human Services and the North Carolina General Assembly







We would like to thank the NC Hospital Association for its generosity in allowing us to use its conference rooms for Task Force meetings. The work of the Task Force was funded by the NC Department of Health and Human Services.

The full text of this report is available on line at: www.nciom.org.

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Chartered in 1983 by the North Carolina General Assembly, the North Carolina Institute of Medicine (NC IOM) is an independent, nonprofit organization that serves as a non-political source of analysis and advice on issues of relevance to the health of North Carolina's population. The Institute is a convenor of persons and organizations with health-relevant expertise, a provider of carefully conducted studies of complex and often controversial health issues, and a source of advice regarding available options for problem solution.

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NORTH CAROLINA HEALTH CHOICE: 2003

REPORT OF THE NORTH CAROLINA INSTITUTE OF MEDICINE
TASK FORCE ON THE NC HEALTH CHOICE PROGRAM

Submitted by the North Carolina Institute of Medicine to the North Carolina Department of Health and Human Services and the North Carolina General Assembly

February 2003

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CHARGE TO THE TASK FORCE

The Secretary of the North Carolina Department of Health and Human Services, the Honorable Carmen Hooker Odom, asked the North Carolina Institute of Medicine (NC IOM) to convene a task force to study options to ensure the long-term financial viability of the NC Health Choice program given the current fiscal constraints of the state budget. The Task Force was asked to explore different options, including changes in enrollment, benefits, utilization, and professional reimbursement rates. The NC General Assembly specifically charged the Task Force with examining health professional reimbursement rates under this program.[1]

The Task Force was charged with exploring options to ensure the long-term financial viability of the NC Health Choice program.

Secretary Hooker Odom, and Olson Huff, MD, Senior Fellow, NC Child Advocacy Institute, Past President of the North Carolina Pediatric Society, and founding Medical Director of the Ruth and Billy Graham Children's Health Center, co-chaired the Task Force. The Task Force was comprised of 28 members, including legislators, staff within the Governor's Office, health professionals, representatives of different provider organizations, and child and health consumer advocates. Pam Silberman, JD, DrPH, Vice President of the NC Institute of Medicine, and Gordon H. DeFriese, PhD, President and CEO of the NC Institute of Medicine, were the primary staff to the Task Force. In addition, the work of the Task Force was supported by staff of the NC Institute of Medicine, NC Division of Medical Assistance, Women's and Children's Health Section of the NC Division of Public Health, NC Teachers' and State Employees' Health Plan, Blue Cross Blue Shield of North Carolina, and Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill.

The Task Force met on four occasions, from October 2002 through January 2003. This report reflects the work of the Task Force. It is divided into six sections: overview of the NC Health Choice, program evaluation, program financing, program expenditures, recommendations and summary of fiscal and cost effectiveness implications. Other options considered but rejected are included in Appendix A.

[1] Chapter 126 of the 2002 Session Law § 10.20(c). "It is the intent of the General Assembly to consider the recommendations of the Institute of Medicine study in determining whether Medicaid rates or some other rates should apply to Program services."

OVERVIEW OF NC HEALTH CHOICE

Background

The NC Health Choice program provides comprehensive health coverage for certain low- and moderate-income children. To qualify, children must be uninsured, ineligible for Medicaid, and have family incomes that are equal to or less than 200% of the federal poverty guidelines.

The NC Health Choice program provides comprehensive health benefits for certain low- and moderate-income uninsured children. The program is one of the State Children's Health Insurance Programs (SCHIP), authorized by Congress as part of the Balanced Budget Act of 1997. To qualify, children must be uninsured, ineligible for Medicaid, and have a family income that is equal to or less than 200% of the federal poverty guidelines (currently $3,017/month for a family of four). The program first started enrolling children in October 1998. Unlike Medicaid, NC Health Choice is not an "entitlement" program, which means, among other things, that the program must operate within specific budget parameters.

The NC Health Choice program is administered jointly by the Division of Medical Assistance (DMA) and the Division of Public Health (DPH) within the NC Department of Health and Human Services (DHHS), and the NC Teachers' and State Employees' Comprehensive Major Medical Plan (hereinafter the State Employees' Health Plan or SEHP). DMA provides oversight for the program, and establishes eligibility policy. DPH is responsible for outreach efforts and for services to children with special health care needs. The State Employees' Health Plan administers the benefits, and contracts with Blue Cross Blue Shield of North Carolina (BCBSNC) to pay claims.

The NC Health Choice program provides comprehensive benefits, including, but not limited to: primary care and preventive services, inpatient and outpatient hospital services, prescription drugs, mental health and substance abuse treatment, durable medical equipment, therapy services, vision, hearing, and dental. Children with special health care needs[2] who need services that are not covered under the traditional benefits package may obtain additional services if authorized by the Women's and Children's Health Section of the Division of Public Health. Children with special health care needs are eligible for most of the same benefits as available under the Medicaid program, including additional durable medical equipment and assistive technology; additional speech, physical or nutritional therapy; enteral formulas and supplies; day

[2] Children with special health care needs must have been diagnosed as having one or more of the following conditions which in the opinion of the diagnosing physician (i) is likely to continue indefinitely, (ii) interferes with daily routine, and (iii) requires extensive medical intervention and extensive family management:

- Birth defect, including genetic, congenital, or acquired disorders;
- Developmental disability as defined under N.C.G.S. § 122C-3;
- Mental or behavioral disorder; or
- Chronic or complex illness.

treatment; high-risk intervention; case management; and community based services.

Families with incomes above 150% of the federal poverty guidelines must pay a one-time application fee and co-payments for certain health services.

Families with higher incomes are expected to contribute to the costs of the program. Families with incomes in excess of 150% of the federal poverty guidelines must pay an annual enrollment fee of $50 for one child or $100 for two or more children before enrolling. In addition, they must pay certain co-payments, including:

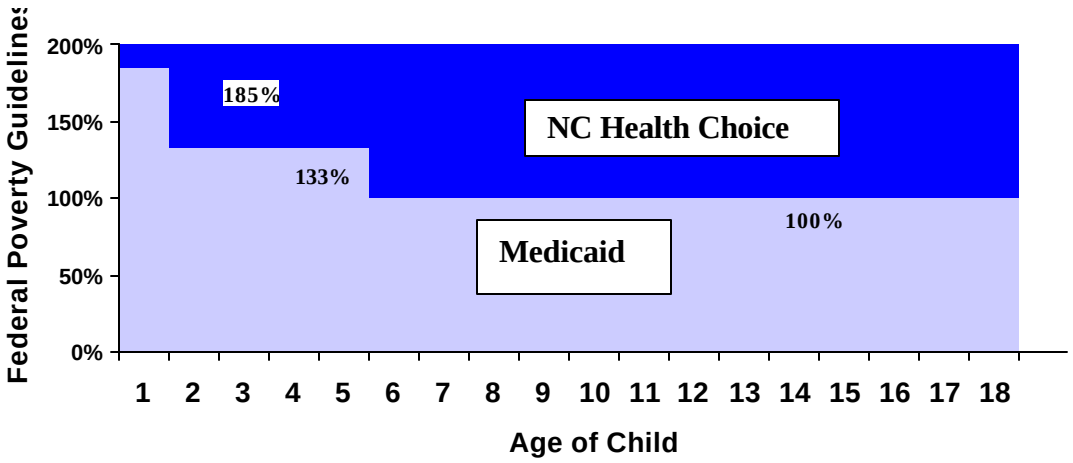
- $5 for each physician visit, clinic visit, dental, or optometry visit, except that there are no co-payments for preventive services (screenings or immunizations)
- $5 for each outpatient hospital visit
- $6 for each prescription
- $20 for each visit to the emergency room (this co-payment is waived if the child is admitted to the hospital)

Families who are interested in applying for NC Health Choice can obtain applications at multiple locations, such as the local Departments of Social Services, health departments, community health centers, many private providers, some schools and daycare centers, a toll-free hotline, and on the DMA's website. Eligibility is determined by local Departments of Social Services (DSS). Children are first screened to determine if they are eligible for Medicaid, and if so, they are enrolled into Medicaid. Eligibility for Medicaid is based on the child's age and family income (as a percentage of the federal poverty guidelines), with higher income eligibility limits for younger children (See Chart 1). If the family's income exceeds the Medicaid income limits, then DSS will determine if the child is eligible for NC Health Choice.

Because of Medicaid's different income eligibility thresholds, Medicaid may cover the younger children in a family, while NC Health Choice covers their older siblings. Children who are eligible for Medicaid are eligible for one-year continuous enrollment, unless the child ages out of a particular income eligibility category. In this event, local DSS must assess the child's eligibility for NC Health Choice based on the income and other eligibility information already contained in the file. If the child is determined to be eligible for NC Health Choice, he or she will be automatically "rolled-over" into the program.

Children are first screened to determine if they are eligible for Medicaid, and if so, they are enrolled into Medicaid. If the family's income exceeds the Medicaid income limits, then DSS will determine if the child is eligible for NC Health Choice.

Chart 1
Income Eligibility Guidelines for Medicaid and NC Health Choice (By Age)



Children who are determined to be eligible for NC Health Choice are also entitled to one-year continuous enrollment. Children enrolled in either Medicaid or NC Health Choice must reapply at the end of the one-year enrollment period. To continue to receive NC Health Choice benefits, the family must send in the completed recertification form, be determined to be eligible, and pay the annual enrollment fee (if applicable).

Delivery system:

NC Health Choice operates much like the State Employees' Health Plan. Children can obtain care from any provider in North Carolina. This is different than Medicaid, where children are required to select a primary care provider to coordinate their care. Medicaid's Carolina Access I, which operates throughout the state, helps link Medicaid recipients to primary care providers. Primary care providers are responsible for managing the care of their patients, which includes the provision of regular primary care services, making referrals for specialty care and non-emergency hospitalizations, and ensuring telephone coverage 24 hours a day/7 days a week. Carolina Access II/III currently operates in 11 counties (plus one multi-county network) around the state, and focuses on population health management for individuals with certain high-cost, chronic or complex medical conditions.[3] Primary care providers are

[3] This model is built around provider-led community networks that include, at a minimum, local primary care providers, a local hospital, Department of Social Services (DSS), and the health department. Each network is responsible for population health management—identifying individuals with certain high-cost or complex health conditions in need of case management. Access II and III networks are paid $2.50 pmpm

responsible for managing the health of Medicaid recipients with certain high-cost, complex or chronic conditions. Care coordinators play a central role in Access II and III sites, and help identify patients with high-risk conditions or needs, assist providers in disease management education and/or follow-up, work directly with patients to help coordinate their care or access needed services, and collect data on process and outcome measures.

In the NC Health Choice program, children can obtain care from any provider in North Carolina. This is different than Medicaid, where children are required to select a primary care provider to coordinate their care.

While children are not subject to the same type of care coordination in NC Health Choice as they receive in Medicaid (particularly in the Carolina Access II/III counties), children in the NC Health Choice program do have some care coordination. There are a number of separate systems in place to manage certain aspects of the care provided to children enrolled in NC Health Choice:

- *Behavioral health benefits*: The State Employees' Health Plan contracts with ValueOptions, Inc. to manage their behavioral health benefits. All behavioral health services, with the exception of the first 26 outpatient psychotherapy visits, must be precertified by ValueOptions as medically necessary. Specifically, ValueOptions must precertify inpatient admissions, residential treatment center admissions, partial hospitalization services, services in an intensive outpatient program, and outpatient psychotherapy (after the first 26 visits). In addition, ValueOptions must precertify intensive case management, community-based services, day treatment, and residential services in licensed group or therapeutic homes for children with special health care needs.

- *Pharmacy benefits*: The SEHP contracts with Advance PCS, a pharmacy benefits manager to manage the SEHP drug benefits. Because most of the medications that children use are not on the prior authorization list, Advance PCS does little prior authorization for the NC Health Choice children. However, Advance PCS may contact the pharmacy or prescribing doctor if certain issues are flagged (for example, if two drugs are contraindicated).

- *Disease management for children with asthma*: Advance PCS also has a contract to help manage the care of children with asthma. Advance PCS identified children with asthma through claims data (specifically identifying children who used the Emergency Room with a diagnosis of asthma or those who use certain medications). Advance PCS then works through the child's primary care provider (PCP), asking the PCP and his or her nurse to help manage the care of the child.

(in addition to the $2.50 pmpm paid to primary care providers to coordinate care), which must be used for managed care activities such as hiring care coordinators, conducting risk assessments, and operating targeted disease and care management initiatives.

Advance PCS may send the patient educational materials, but typically does not communicate directly with the patients or their families by phone or in-person to manage their care.

- *Children with special health care needs*: Children with special health care needs may obtain case management services if authorized by the Women's and Children's Health Section of the Division of Public Health. Currently, most case management is provided by local area mental health programs. Case management includes service coordination activities designed to meet the educational, vocational, residential, mental health treatment, financial, social and other non-treatment needs of the individual.

- *Use of the emergency room*: In July 2002, the SEHP entered into a contract with the Carolina Access II/III program to pay for case management services in 11 counties to reduce the unnecessary use of the emergency room for NC Health Choice enrollees. Case managers will identify children who have visited the emergency room at least once in a six-month period. The case manager will contact each enrollee by phone to determine if the child has a primary care provider (and to help the child develop a relationship if none exists); encourage the family to use the primary care provider as the first point of contact; identify the reason for the emergency room visit; and assess the child for risk factors. Children who use the emergency room three or more times within a six month period will have more intensive case management, including the possibility of a face-to-face contact, and ongoing telephonic follow-up to ensure that children's appointments are being kept and that the child is receiving appropriate care.

Another major difference between NC Health Choice and Medicaid is the insurance card. Children enrolled in NC Health Choice receive an insurance card that looks the same as a private insurance card. In contrast, Medicaid provides a larger, wallet-sized card that is easily recognized. In a series of focus groups with parents of children enrolled in NC Health Choice, the insurance card was noted as a positive feature of the program.[4] One parent noted:

> *It's more dignified than Medicaid. It's the size of that (Medicaid) card—the big blue card. This (NC Health Choice) looks like a normal insurance card. It feels better.*

[4] Silberman P, Slifkin R, Walsh J, Poley S. The North Carolina Enrollment Freeze of 2001: Health Risks and Financial Hardships for Working Families. Kaiser Commission on Medicaid and the Uninsured.

Enrollment Cap: January 1, 2001 to October 8, 2001

North Carolina has been recognized as one of the national leaders in enrolling uninsured children in its State Children's Health Insurance Program. Based on estimates provided from the federal government, DHHS and the General Assembly initially estimated that there were approximately 71,000 uninsured children who would be eligible for NC Health Choice. However, growth in program enrollment quickly exceeded that estimate—so that by the end of December 2000, there were more than 72,000 children enrolled. DHHS capped enrollment beginning in January 2001 to assure that the program operated within its state and federal budgets. With the bifurcated program administration, DHHS has no other options than to cap enrollment when program costs exceed state appropriations, as DHHS has primary responsibility for program enrollment but not professional reimbursement levels or utilization control (which is controlled by the State Employees' Health Plan).

Because of the way the program is structured, the NC Department of Health and Human Services has authority to freeze or cap enrollment, but not to change the program design, reduce professional reimbursement rates or impose other utilization controls to ensure the program operates within the state budget.

Children who were already enrolled in NC Health Choice continued to receive coverage during the enrollment cap. They retained coverage after their one-year eligibility period if they returned a recertification form within the specified time period and were determined to be eligible. Other children, including new applicants, children who were no longer eligible for Medicaid due to increases in family income or aging out of income eligibility categories, and children on NC Health Choice whose parents did not return the reenrollment documents in a timely manner were put on a waiting list if they were determined to be eligible for NC Health Choice. Children who were on Medicaid who would ordinarily be "rolled-over" into NC Health Choice were caught in the NC Health Choice enrollment cap.

During the enrollment cap in 2001, enrollment in NC Health Choice dropped from a high of 72,024 in the beginning of January, to 51,294 in October.

NC Health Choice enrollment dropped from a high of 72,024 at the beginning of January 2001, to 59,472 children by June of that year. Children lost eligibility because their family income changed, they aged out of the program, or failed to reapply in time. In July 2001, as a result of this decline in enrollment, the state began to process the applications of families on the waiting list on a first-come, first-serve basis. Despite the partial reopening of NC Health Choice in July, enrollment continued to drop until it reached a low of 51,294 in October 2001. The 2001 General Assembly appropriated an additional $8 million for SFY 2002 and $12.5 million in SFY 03 to provide coverage to up to 82,000 children. The enrollment cap was officially ended for new applicants on October 8, 2001.

There were 34,282 children who were determined to be eligible for NC Health Choice, but put on the waiting list during the enrollment freeze.

Most of the children who were receiving NC Health Choice prior to the enrollment freeze continued their coverage.[5] There were 53,340 children enrolled in NC Health Choice who had re-enrollment dates during the enrollment cap. Approximately half of these children (49.0%) were recertified and remained on NC Health Choice, and another 20.9% qualified for Medicaid. Some children (5.1%) were determined to be ineligible for NC Health Choice or Medicaid—presumably because their family income had increased. Only 1,537 children (2.9%) were put on the waiting list because they failed to return their recertification forms within the prescribed time frame. Almost one-fourth (22.0%) of the previously covered children never returned their recertification forms. There is no way of knowing what happened to these children.

Local DSS offices determined eligibility for NC Health Choice before placing the child on the waiting list. More than half of these children (60.0%) had been receiving Medicaid, but were unable to "roll-over" because of the enrollment cap. A little over one-third (35.5%) were new applicants to Medicaid or NC Health Choice. Only 4.5% (1,537 children) were children who had previously been covered by the program, but failed to reapply in time (discussed previously).

Almost half of the children on the waiting list (47.2%) ultimately received NC Health Choice coverage when the program re-opened. Another quarter (24.5%) were enrolled in Medicaid, which means that their family income decreased after they were placed on the waiting list. The remaining 28.4% did not qualify for NC Health Choice or Medicaid when their application reopened, or could not be located.

The Kaiser Commission on Medicaid and the Uninsured contracted with the Cecil G. Sheps Center for Health Services Research at UNC-Chapel Hill to conduct a series of focus groups of the parents of children caught in the enrollment freeze. The parents who participated in the focus groups reported that the enrollment cap caused significant hardship for their families. Almost all of the parents reported that their children needed health care at some point when their child was on the waiting list and uninsured. Children needed care for common illnesses, such as colds, fevers, bronchitis, and flu, to more serious concerns with asthma and potentially life threatening infections. Most parents were ultimately able to get the care their children needed, but they reported that they delayed care or incurred large bills. Many families tried to obtain other health insurance coverage for their children during the enrollment freeze, but most were unable to afford the monthly premium costs, even when it was available through their or their spouse's employer. Seventeen percent of

[5] Silberman P, Slifkin R, Walsh J, Poley S. Experiences of North Carolina Children During SCHIP Enrollment Freeze. Accepted for Publication. Kaiser Commission on Medicaid and the Uninsured.

the participants did get private health insurance coverage during the waiting period.

NC Health Choice program growth post enrollment cap

NC Health Choice enrollment grew rapidly after the program was reopened. The NC Department of Health and Human Services was again faced with the prospect of freezing the program. However, the NC General Assembly appropriated an additional $7.7 million in non-recurring funds to enable the program to remain open pending the Task Force's work.

Enrollment grew rapidly once the program was reopened. Between November 2001 and June 2002, enrollment grew at more than 5% a month. By July 1, 2002, there were 84,286 children enrolled in the program. Program growth has subsequently slowed, but enrollment is still generally growing at 1-3% per month. Once again, the Department was faced with freezing the program, and announced that the program would be frozen beginning September 1, 2002. At the same time, Secretary Hooker Odom asked the NC Institute of Medicine to convene a Task Force to develop options to ensure the long-term financial solvency of the program. The General Assembly initially considered several options to reduce overall program costs, but chose to delay implementing any of the proposed program changes until the Task Force could issue its report in early 2003. The General Assembly also appropriated an additional $7.74 million in non-recurring funds in addition to the earlier $12.5 million appropriation in SFY 03 to cover approximately 100,000 children. Because of the creation of the Task Force, and the infusion of new funds, the program was not capped.

EVALUATION OF NC HEALTH CHOICE

Within a year of the program's inception, the Department of Health and Human Services contracted with the Cecil G. Sheps Center for Health Services Research at The University of North Carolina in Chapel Hill to evaluate the NC Health Choice program. The Cecil G. Sheps Center for Health Services Research conducted two evaluations that helped the Task Force with its deliberations. The first examined the effects of the program on beneficiary access to care, and the second was a cross-insurance comparison of children with special health care needs.

Beneficiary Access to Care

The Division of Medical Assistance contracted with the Cecil G. Sheps Center for Health Services Research to conduct a study on access to care for NC Health Choice enrollees.[6] The study explored the perceptions of

[6] Slifkin RT, Freeman VA, Silberman P, Schwartz B. Assessing the Effects of the North Carolina Health Choice Program on Beneficiary Access to Care. Final Report. Submitted to the N.C. Division of Medical Assistance. Sept. 25, 2001. Slifkin RT, Freeman VA, Silberman P. Effect of the North Carolina State Children's Health Insurance Program on Beneficiary Access to Care. Arch Pediatr Adolesc Med. Dec. 2002;156:1223-1229. Mofidi M, Slifkin R, Freeman V, Silberman P. The Impact of a

parents of children enrolled in NC Health Choice regarding their children's access to health care services before and after enrollment in the program.

An evaluation of the NC Health Choice program showed that access to health care services improved for low-income children. Parents reported that their children were healthier and performed better in daily activities.

The study included two waves of surveys—the initial survey was sent to 1800 parents of newly enrolled children to find out about their child's health status, health care experience, and access to care before enrollment in NC Health Choice. Parents who responded with baseline data for their children were re-surveyed one year later to collect information on their child's experiences while insured by NC Health Choice. Children were divided into three age groups: 0-5 years old, 6-11 years old, and 12-18 years old. Response rates to each survey were approximately 75% and yielded a study sample of 314-348 children in each age cohort for whom parents reported data in both years.

Parents were asked whether their child:

- Had a provider for checkups
- Received checkups in the private sector
- Had a checkup in the last year
- Received acute care from a private sector provider
- Had unmet health care need

After enrollment in NC Health Choice, more children were reported to receive well-child and acute care in the private sector. Waiting times for acute care appointments decreased. Children were also less likely to rely on emergency rooms as their sole source of care, although more children were reported to have made an emergency room visit after enrolling in NC Health Choice than before enrollment. Study results indicate that the program has been successful in improving access to health care for low-income children. Parents reported that the program helped make health services financially accessible to their children, and that it enabled them to obtain physician's care, eye glasses, dental care, and prescription drugs that their children needed. They also reported that their children were healthier and performed better in their daily activities.

The study examined changes in access to care for Medicaid graduates compared to previously uninsured children. Medicaid graduates made up 68% of the sample (90% of the babies). Children who were uninsured for at least six months were considered uninsured (16% of the sample). The remaining 16%, i.e., children who had been on Medicaid or had private health insurance coverage more than one month but less than six months prior to enrollment, were not included in this sub-analysis. The study

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State Children's Health Insurance Program on Access to Dental Care. JADA. 2002;133:707-14.

found that Medicaid children had better access to services than did uninsured children prior to enrolling in NC Health Choice. Access for both groups improved after enrolling in NC Health Choice, but the improvement appeared to be greater for the previously uninsured children than for Medicaid graduates.

However, despite these overall improvements, there are still substantial numbers of children who did not receive age-appropriate well-child care in their first year on NC Health Choice. For babies and preschoolers (birth through age five), there was a significant decline in the percentage of parents of children previously enrolled in Medicaid who reported that their children had received a well-child checkup in the year since enrolling in NC Health Choice. This may be explained, in part, by the loss of support that comes with Medicaid coverage. In most counties, DSS hires Health Check (Medicaid) coordinators who help remind families to make appointments for needed well-child visits, and arrange transportation when needed. The Health Check coordinators will also follow-up if a child misses an appointment. This system does not exist in the NC Health Choice program.

Access to dental services still appears to be a problem for NC Health Choice enrollees, although not as great a problem as it is for Medicaid enrollees. Parents had more difficulty finding dentists willing to accept NC Health Choice than willing physicians. Reported unmet needs were also higher for dental care. While reported unmet medical needs significantly decreased after program enrollment, almost one-fifth of parents of school-aged children still reported unmet dental needs.

Overall, the vast majority of parents appear to be delighted with NC Health Choice and feel that their children are healthier, have better access to needed care, and are more able to participate in normal childhood activities because of this insurance coverage. Prior to enrollment in the program, several parents reported that their child could not participate in sports, field trips, and other types of school activities because of lack of health insurance. With NC Health Choice coverage, this barrier has been removed.

Cross Insurance Comparison of Children with Special Health Care Needs

The Women's and Children's Health Section of the Division of Public Health (NC DHHS) contracted with the Cecil G. Sheps Center for Health Services Research at UNC-Chapel Hill to study children with special health care needs (CSHCN) enrolled in NC Health Choice, Medicaid, and the State Employees' Health Plan.[7] The study examines access to medical

[7] Freeman V, Slifkin RT, Schwartz R, Farel AM. A Cross Insurance Comparison of North Carolina Children with Special Health Care Needs. Preliminary Report.

Children with special health care needs covered by NC Health Choice, Medicaid, and the State Employees' Health Plan were generally able to access needed medical services. Access to dental services was more difficult, particularly for Medicaid children.

care, mental health services, dental care, and ancillary services through a mailed survey. CSHCN were identified using ICD-9 codes from insurance claims, and included children with asthma, ADD/ADHD, developmental delay, mental health conditions, and other diseases or chronic health conditions.[8]

The study found that the site of care varied by insurance source. Medicaid children were more likely to be seen in the public sector, i.e., a health department or community health center. Almost none of the State Employees' Health Plan children were treated in public health facilities. NC Health Choice children were more likely to use public providers than were State Employees' Health Plan children, but less likely than Medicaid children.

While the site of care was different for participants in these three types of insurance, the reported access barriers did not differ substantially across insurance plans for most types of care. Children enrolled in Medicaid were slightly more likely to report unmet health needs (approximately 10% of Medicaid-eligible children reported access barriers, compared to 5% among NC Health Choice children and 4% among children of state employees).[9] However, less than 2% of each insured group reported that the reason they could not obtain needed care was the inability to find a provider who would accept their insurance.

The largest variations in access were in dental services and equipment and supplies. More NC Health Choice parents reported their children were seen in a private dental office, and fewer reported that their child had no dentist than did parents of Medicaid children. However, both NC Health Choice and Medicaid children were more likely to report having access barriers to dental services than for other services. Twenty-three percent of Medicaid children and 18% of NC Health Choice children were reported to need dental care that they were unable to get. Parents of 14% of Medicaid children and 8% of NC Health Choice children reported that the dentist would not accept their insurance. There were also variations in access to needed equipment and supplies. Of those parents who reported that their children needed special medical equipment of supplies, 25% of NC Health Choice, 14% of Medicaid, and 11% of SEHP parents reported that they could not get the equipment their child needed. In each insurance category, the most frequent reason reported for the inability to

[8] Not all of the children in the study were reported by their parents to have special health care needs. Children could have been incorrectly identified due to coding mistakes, or if they were seen by a provider in order to "rule-out" certain health conditions. In addition, parents may not view their child's condition as chronic, e.g., a child with a congenital heart defect that has been repaired.

[9] The actual percentage of families reporting unmet needs varies depending on the type of care sought: primary care, specialty care, ADD/ADHD treatment or counseling, mental health/substance abuse, dental care, prescription drugs, or equipment or supplies.

obtain needed equipment was that the insurance did not cover the equipment the child needed.

NC HEALTH CHOICE FINANCING

The NC Health Choice program is financed jointly by the federal and state government. The federal government pays 73.6% of program costs,[10] with the remaining 26.4% contributed by the state. Unlike the North Carolina Medicaid program, counties are not required to contribute to the costs of the NC Health Choice program.[11]

The federal government pays almost three-quarters of NC Health Choice program costs.

The federal government allocates a certain amount of money to each state every year. The federal allocation is determined under a complex formula that includes the number of uninsured children with family incomes under 200% of the federal poverty guidelines, and the number of children covered through the State Children's Health Insurance Program.[12] North Carolina's federal allotment increases from $79.5 million in federal fiscal year (FFY) 1998 to a high of $129.8 million in FFY 07. However, when the original State Children's Health Insurance Program was enacted, Congress reduced the amount of the federal allotment in FFY 02-04.[13] Because of this reduction, the state also has a reduction in their federal allotment during those years.

FFY 98: $79.5 million	FFY 03: $81.7 million
FFY 99: $79.1 million	FFY 04: $81.7 million (est.)
FFY 00: $89.2 million	FFY 05: $105.1 million (est.)
FFY 01: $103.7 million	FFY 06: $105.1 million (est.)
FFY 02: $81.1 million	FFY 07: $129.8 million (est.)

States can carry forward federal funds for up to three years, after which any unspent federal allotments will be returned to the federal government for redistribution to states that have spent their full federal allotment. States have only one year to spend the redistributed money, or it will again revert to the federal government. Historically, North Carolina has spent the majority of its federal allotment as well as some redistributed federal funds (Table 1). However, because of the program freeze (reducing the

[10] Under federal SCHIP law, the federal government pays a higher match rate (effectively paying 30% of the non-federal share of the Medicaid match rate). In FFY03, the federal government will contribute 62.56% towards Medicaid service expenditures and 73.79% of the NC Health Choice service expenditures (October 2002-Sept 2003).
[11] Under state law, counties are required to pay 15% of the non-federal share of the Medicaid service costs (currently 5.62%).
[12] The federal regulations can be found at: http://www.cms.gov/schip/21fmreg.pdf
[13] Congress initially enacted this dip in federal funding during FFY 02-04 because at the time of the original legislation (1997), this money was needed to balance the federal budget.

overall program expenditures), and the inability to obtain state matching funds outside of a normal budget cycle,[14] North Carolina was unable to spend all of its base allotment or some of the redistributed monies in 2002.

Table 1
Expended and Unexpended SCHIP Federal Allotments (1998-2000)

	NC Allotment	Expended	Unexpended	Date of Reversion to Feds
FY98	$79,508,462	$79,508,462	$0	9-30-2000
FY 98 Redistributed	$20,902,191	$20,902,191	$0	9-30-2001
FY 99	$79,132,966	$79,132,966	$0	9-30-2001
FY99 Redistributed	$92,146,880	$0	$92,146,880	9-30-2002
FY 00	$89,211,202	$77,768,983	$11,442,219	9-30-2002

Source: Gambill A. Division of Medical Assistance. Presentation to NC Health Choice Task Force. October 8, 2002.

Assuming that the General Assembly continues to appropriate $45.1 million, the same amount in SFY 04 that was appropriated in SFY 03, the program will still experience a shortfall in the next fiscal year (Table 2). Absent changes in enrollment, utilization or costs, NC Health Choice will need an additional $8.6 million dollars in SFY 04, and then $9 million more in SFY 05. The state will experience a shortfall in federal funds in SFY 06, although the Task Force thought the estimated federal shortfall may be a "worst-case scenario" as North Carolina may receive future redistributed monies that could forestall or eliminate the potential federal budget shortfall.

[14] North Carolina qualified for FFY 99 redistributed funds, but we did not receive official notice of the redistribution until March 2002. However, by that time, the state budget was set so DHHS could not obtain the needed state match.

Table 2
Federal and State Funds Needed and Available (SFY 04-07)

SFY	Members	Premium	Total	Fed'l $ Needed	Fed'l $ Avail.	Fed'l Short.	State $ Needed	State Approp.	State Short.
04	105,768	$159.03	$204.1m	$150.9m	$150.9m	$0	$53.2m	$45.1m	($8.1m)
05	109,846	$178.11	$237.0m	$175.0m	$175.0m	$0	$62.0m	$45.1m	($16.9m)
06	114,858	$199.49	$277.2m	$204.2m	$107.2m	($97.1m)	$73.0m	$45.1m	($27.9m)
07	119,871	$223.42	$323.6m	$238.3m	$129.8m	($108.6m)	$85.3m	$45.1m	($40.2m)

Source: Gambill A. Division of Medical Assistance. Presentation to NC Health Choice Task Force. October 8, 2002. Note: There are additional federal funds available in SFY 04 and 05, because the state did not use the full federal allotment in prior years and has been able to carry forward some of the federal funds. Under the current assumptions, the state will have no federal funds to carry forward by SFY 06.

NC HEALTH CHOICE PROGRAM EXPENDITURES

Growth in NC Health Choice program expenditures is a function of three factors: (1) number of eligibles, (2) professional reimbursement rates and cost of services, and (3) utilization. Over the last four years, all three of these factors have increased, leading to an increase in overall program expenditures. Even after controlling for increases in eligibles, the overall cost of the program per member per month has increased 26.7% over the last four years.

The growth in the costs of the NC Health Choice program is similar to increases in Medicaid and commercial health insurance products.

The growth in the costs of the NC Health Choice program is similar to increases experienced in other publicly and privately financed insurance programs (Table 3).

Table 3
Increases in Per Member Per Month (PMPM) Costs
Among Different Health Insurance Products (1999-2002)

	NC Health Choice per member per month (pmpm)	Medicaid for Infants and Children (MIC) (pmpm)	State Employees' Health Plan for children (pmpm)	Commercial Premiums
SFY 99		-3.7%	7.5%	7.3
SFY 00	9.0%	-2.8%	9.9%	8.1
SFY 01	7.2%	14.0%	14.2%	11.1
SFY 02	8.4%	8.6%	1.6%[a]	12.7

State Employees' Health Plan and NC Health Choice data were obtained from AON Consulting, State Employees' Health Plan. January 2003. Medicaid data from Cobb R. Division of Medical Assistance. January 2003. Commercial premium data from Mercer/Foster Higgins National Survey of Employer Sponsored Health Plans. March 2002. This reflects increase in premium prices for the calendar years 1999, 2000, 2001, 2002. The estimate for the increase in premium prices for 2003 is 14.7%.

[a] In SFY 2002, the State Employees' Health Plan reduced provider reimbursement rates and also made benefit changes, which shifted some of the costs onto the employees. This resulted in a 12% reduction in claims due to benefit changes and provider reimbursement reductions, of which 8% was due to benefit changes, and 4% due to changes in professional reimbursement rates. Without these changes, the actual increase in pmpm costs would have been closer to 13-14%.

Expenditures per member per month are expected to grow at least 12% per year for the foreseeable future. This anticipated growth in program costs per member per month is due to increases in utilization and increases in the cost of services. Mercer Human Resource Consulting reported that the increases are due to a combination of factors, including a backlash against managed care, new technology and greater use of diagnostic equipment, expensive medicines, and increases in hospital costs.[15]

Numbers of Eligible Children

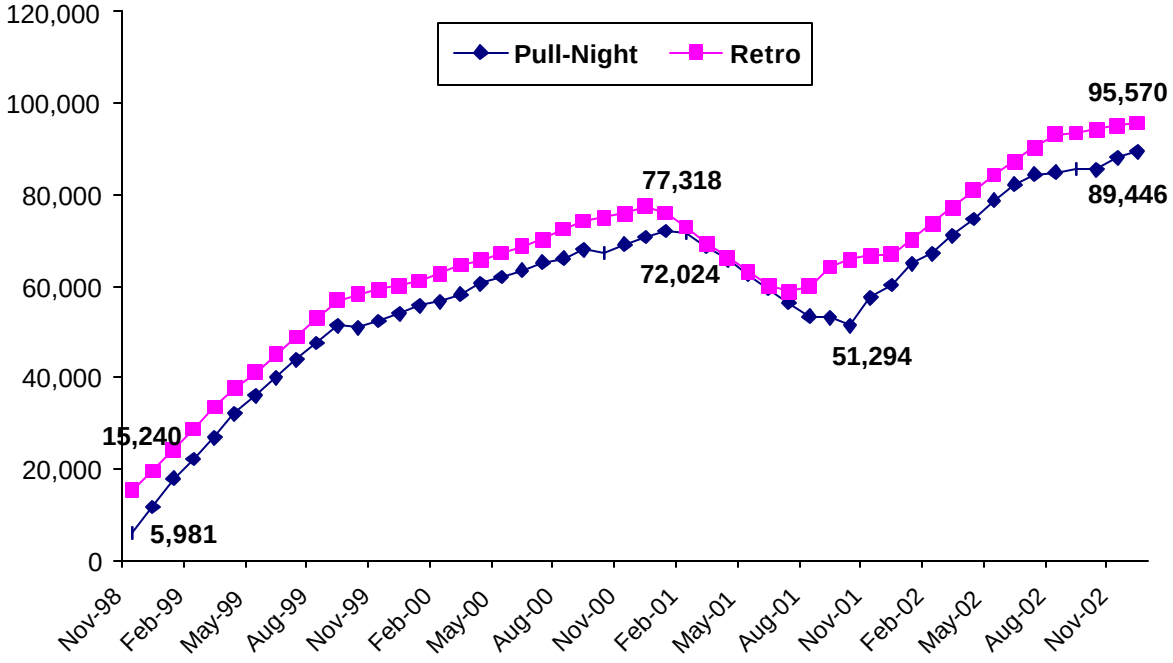
There were more than 90,000 children enrolled in the NC Health Choice program in December 2002.

The number of children enrolled in NC Health Choice grew from 5,981 in the first month of enrollment to more than 89,000 in December 2002, based on the eligibles counted on a specific date each month (called "pull-night") (See Chart 2). There are two different ways of counting eligibles: point-in-time estimates, and eligibility numbers including those who are retroactively found to be eligible for NC Health Choice. The Division of Medical Assistance uses a specific day of each month, called "pull-night," to determine the number of people covered by Medicaid or NC Health Choice. According to this estimate, there were 89,446 children eligible for

[15] White, Los Angeles Times, Dec. 9, 2002

NC Health Choice on January 1, 2003. However, this point-in-time estimate does not include children who are later found to be eligible. For example, a child who applies on December 1st may not have his or her eligibility determined until January 5th. If the child is determined to be eligible, coverage will be provided for any covered services obtained as of December 1st (the date of application). This child would not be included in any estimates of eligibles based on the December pull-night, but would be included at a later date if including all the children who were retroactively determined to be eligible. This later count, which includes retroactive eligibles, is approximately 8% higher than the estimates based on the pull night.[16]

Chart 2
Enrollment Growth in NC Health Choice
(Nov. 98-December 2002)



Source: Division of Medical Assistance. January 2003.

Because very young children can qualify for Medicaid with higher family incomes (up to 185% of the federal poverty guidelines), few children under age one qualify for NC Health Choice (Table 4). Children under age one constituted less than one percent (0.1%) of the NC Health Choice enrollees in December 2002. Slightly more than one-fifth (21.2%) of the NC Health Choice enrollees were children ages one through five.

[16] The retroactive counts of eligibles usually takes about three-four months before all the eligibles are included.

Children age six through ten constituted more than one-third (34.4%) of the NC Health Choice enrollees, and children ages 10-13, comprised 20.1% of the enrollees. Older children ages 14-18 made up the remainder (24.1%).

Table 4
Age of Children on NC Health Choice (December 2002)

Age	(%)	Age	(%)
< 1	(0.1%)	10	(7.0%)
1	(4.5%)	11	(7.0%)
2	(4.5%)	12	(6.8%)
3	(4.3%)	13	(6.4%)
4	(4.1%)	14	(5.8%)
5	(3.9%)	15	(5.5%)
6	(6.1%)	16	(5.0%)
7	(7.0%)	17	(4.4%)
8	(7.3%)	18	(3.3%)
9	(7.1%)	19*	(0.2%)

Source: Division of Medical Assistance.
*Note: Children can receive NC Health Choice until the end of the month in which they turn 19.

Realistic estimates of the numbers of potentially eligible children are needed to properly budget for program growth.

The General Assembly appropriated sufficient funds to cover approximately 100,000 children in SFY 2003. The NC Health Choice program has been extremely successful in enrolling uninsured children. As a result, it exceeded enrollment predictions on at least two occasions in the past, causing state budget shortfalls. Realistic estimates of the numbers of potentially eligible children are required to ensure the long-term financial viability of the program.

One of the most difficult tasks the Task Force faced was to estimate the number of potentially eligible children. When NC Health Choice was first developed, the state used the estimates of uninsured children derived from the Current Population Survey (CPS), a survey conducted by the U.S. Bureau of the Census every March. The CPS is a telephone survey of families that obtains information on the families' income, and the insurance status of every member in the household (among other questions). The federal government uses this information to determine the number of uninsured children below 200% of the federal poverty guidelines in each state. This estimate is also used in allocating the federal SCHIP allotment to the states.

North Carolina also used these data initially to estimate the number of children who were potentially eligible for the program. However, experience showed us that these data are not a reliable source to estimate

the numbers of uninsured, as more children have enrolled in the program than were originally determined to be eligible. The primary problem is that the Census does not survey enough families in North Carolina to be able to make reliable estimates of the number of uninsured children at different ages and income guidelines. In order to determine the number of children who may be eligible for NC Health Choice, the state must first determine whether the children would be eligible for Medicaid (based on age of the child and family income). However, because of the small CPS sample size, there may be only one or two children surveyed in different income cells. For example, there is only one child in the most recent sample who is less than age one, with a family income between 175-200% of the federal poverty guidelines. If that child is uninsured, it will appear as if all children in that age/income group are uninsured, or conversely, if that child has insurance—then all children in that group will appear to have private coverage. Further, the Census data historically undercounts the number of children who are on Medicaid or NC Health Choice.

To try to address these problems, staff from the Cecil G. Sheps Center for Health Services Research tried to develop estimates using actual state-level data (for example, the actual numbers of children enrolled in NC Health Choice and Medicaid) (Table 5). CPS data were only used when other state-level data were unavailable.

Table 5
Estimates of Numbers of Potential Eligible NC Health Choice Children

	<1 (185-200%)	1-5 (133-200%)	6-18 (100-200%)	TOTAL
Number of children Data: Office of State Planning population estimates for different ages, multiplied by the percentage of children in different income cells (from CPS)	1,576	41,379	121,952	164,907
Children currently on NCHC (Data: NC Health Choice actual enrollment data)	*105*	*19,304*	*70,621*	***90,030***
Children on Medicaid (Data: Division of Medical Assistance actual enrollment data)	*838*	*207*	*4,060*	*5,105*
Remainder (Children with unknown insurance status—i.e., can be privately insured, covered by CHAMPUS, uninsured)	633	21,868	47,271	69,772
Percent uninsured (Data: Used CPS to generate the percent of children in different income categories that are uninsured)	*10.34%*	*20.36%*	*22.02%*	
Number uninsured	65	4,452	10,409	**14,927**
Total NCHC Potentials				**104,957**

Source: Slifkin R, PhD, Cecil G. Sheps Center for Health Services Research, Presentation to NC IOM Task Force on NC Health Choice. November 2, 2002.

Based on this analysis, the Sheps Center estimated that there are currently approximately 105,000 children with incomes below 200% of the federal poverty guidelines that could be eligible for NC Health Choice. Of this number, about 90,000 are already covered, leaving approximately 15,000 uninsured eligible children who have not enrolled in the program.[17] The Task Force used this as their baseline estimate of the current number of children who may be eligible for NC Health Choice. Determining the

[17] Using the CPS data, the Census estimated that there are approximately 155,000 children who could be eligible for NC Health Choice—however, CPS historically undercounts the number of children on Medicaid so these estimates are probably overestimates of the numbers of uninsured children.

number of children who may be eligible over the next five years is more difficult, as the growth in the program will be affected by overall population growth and changes in the economy and the cost of private health insurance coverage. According to the Office of State Planning, the total number of children is expected to grow approximately 1.5% per year.[18] Additional children may qualify if families lose some of their income through reduced employment hours, or if premiums get too high to be able to afford private coverage.[19]

After reviewing enrollment history, and realizing that future projections are very difficult to assure, the consensus of the Task Force is that it is reasonable to plan for an enrollment of 100,000 children in the current fiscal year, with increments of an additional 5,000 children in each of the next four fiscal years. These enrollment projections are the basis for the Task Force recommendations with regard to financing.

Professional Reimbursement Rates

Professional reimbursement under the NC Health Choice program is tied to the rates paid by the State Employees' Health Plan.

Professional reimbursement under the NC Health Choice program is tied to the rates paid by the State Employees' Health Plan. The SEHP pays providers their usual, customary and reasonable (UCR) rates, as developed by Blue Cross Blue Shield of North Carolina. BCBSNC first examines the providers' charges and develops a set of "usual" rates (rated from least expensive to most expensive). The customary rate is set at the 90th percentile of usual charges. Any charges in the top 10th percentile are reduced to the customary rates. "Reasonable" rates give BCBSNC the flexibility to increase rates for situations that may be more complex. Doctors can change their charges one time per year. Providers are not paid according to a fee schedule (for example, Medicare's Resource-Based Relative Value Scale), but rather each provider's rate is set separately.

[18] Office of State Budget and Management. North Carolina State Demographics. Projected County Age Groups: Children. July 2002, July 2003, July 2004, July 2005, July 2006, July 2007. Available on the Internet at: http://demog.state.nc.us/ (Accessed January 3, 2003).

[19] If parents lose their jobs altogether, the family income may be reduced enough to have their children qualify for Medicaid.

On average, the State Employees' Health Plan, and consequently NC Health Choice, pays higher rates than Medicare or Medicaid.[20] As a percentage of Medicare rates for the same procedures or services, the State Employees' Health Plan pays:

Hospital inpatient (non-DRG):	163% of the Medicare rates
Hospital outpatient:	150% of the Medicare rates
Primary care:	123% of the Medicare rates
Specialists:	146% of the Medicare rates

These broad categories mask even greater variations in professional reimbursement rates. For example, pediatricians are paid, on average, 110% of Medicare rates while pathologists, radiologists, emergency room physicians, surgeons, physical and occupational therapists are paid more than 200% of Medicare rates. In contrast, Medicaid pays primary and specialty providers 95% of the Medicare rates.[21] Hospitals are paid, on average, approximately 84% of the Medicare rates.

The scheduled changes in the State Employees' Health Plan professional reimbursement rates effective April 1, 2003, will result in a savings to the state of approximately $1.4 million in the NC Health Choice program in SFY 04.

Beginning April 1, 2003, the professional reimbursement rates paid to some health professionals by the State Employees' Health Plan will be reduced. Most of the reductions will be among the rates paid to hospitals for outpatient services and to specialists. Because the NC Health Choice rates are tied to the State Employees' Health Plan rates, the new rates will also reduce professional reimbursement in NC Health Choice. This will result in a net decrease in the costs per member per month of about 3.3% (Table 6). By making this rate adjustment, NC Health Choice will save $5.4 million total, or $1.4 million in state funds in SFY 04 over what the program would have otherwise expended. By SFY 07, savings to the state will increase to $2.4 million.

[20] Presentation by Paul Sebo, Operations Manager, State Health Plan, to the NC IOM NC Health Choice Task Force on October 8, 2002.

[21] Physician reimbursement in the Medicaid program is tied directly to the Medicare Resource Based Relative Value Scale (RBRVS) reimbursement rates; so when Medicare RBRVS reimbursement rates are reduced it effectively also reduces the Medicaid professional reimbursement rates.

Table 6
Changes in NC Health Choice PMPM
from SEHP Changes to Professional Reimbursement Rates
(Effective April 2003)

	SFY04	SFY05	SFY06	SFY07
Membership	105,768	109,846	114,858	119,871
Baseline pmpm	$159.03	$178.11	$199.49	$223.42
Changes in pmpm from professional reimbursement changes	$153.72	$172.10	$192.68	$215.70
Savings $ pmpm	-$5.31	-$6.01	-$6.81	-$7.72
Savings % pmpm	-3.3%	-3.4%%	-3.4%	-3.5%
Total yearly savings	$5,386,631	$6,340,003	$7,501,528	$8,893,293
State yearly savings	$1,403,756	$1,657,277	$1,974,402	$2,343,383

Source: AON Consulting under contract to the State Employees' Health Plan provided information on NC Health Choice pmpm costs and estimated the cost savings from reduced provider reimbursement rates. The analysis was conducted by the Division of Medical Assistance. Feb. 2003.

Utilization

Health care spending is concentrated among a small percentage of individuals. Nationally, approximately 55% of all health care expenditures are spent on behalf of 5% of the population.[22] Approximately half of all people in this country account for only 3% of all U.S. health care expenditures.

Health care expenditures are slightly less concentrated in the NC Health Choice program. In this program, the top 5% of the children account for 42% of the program expenditures.[23] These children in the top 5%, or 4,005 children, spent $9,481/year on average in 2001. Approximately half of all NC Health Choice enrollees, those who use the least services, accounted for only 9% of program expenditures (Table 7).

[22] Berk ML, Monheit AC. The Concentration of Health Care Expenditures, Revisited. Health Affairs, Mar/April 2001;20(2):9-18.

[23] Presentation by Greene S. Cecil G. Sheps Center for Health Services Research, to the NC IOM NC Health Choice Task Force. December 3, 2002. Data made available by BCBSNC.

Table 7
Concentration of Health Spending Among NC Health Choice Children (2001)

Number of NCHC Children	Percent of NCHC Children (cumulative)	Amount of NCHC Expenditures	Average Paid per Child
801	1%	20%	$22,557
4005	5%	42%	$9,481
8010	10%	55%	$6,312
40,046	50%	91%	$2,062
80,091	100%	100%	$1,132

Source: Greene S. Cecil G. Sheps Center for Health Services Research. Presentation to the NC IOM NC Health Choice Task Force. December 3, 2002. Data made available by BCBSNC. Data are presented from highest cost users to lowest cost users.

NC Health Choice children are disproportionately hospitalized for mental disorders and asthma, and treated more frequently on an outpatient basis for attention deficit disorders, otitis media, and respiratory problems.

The Task Force examined the health conditions of the 4,005 high-cost children to determine if their health conditions could be better managed or whether there were other ways to control utilization to reduce program costs. Data from BCBSNC showed that children are disproportionately hospitalized for mental disorders and asthma and treated more frequently on an outpatient basis for attention deficit disorders, otitis media and respiratory problems. The data analyzed included only claims paid under the traditional NC Health Choice benefits package, and did not include the additional services that may be authorized for children with special health care needs. Behavioral health services are the services most often authorized for children with special health care needs.[24]

Further analysis of BCBSNC utilization data showed that there is a small group of children who are using emergency rooms excessively—1,240 children visited the hospital emergency rooms three or more times during the year. In general, the use of emergency rooms for true "emergencies" is similar to the experience of children insured through the State Employees' Health Plan. However, non-emergency use of the emergency room by NC Health Choice children is higher than for other SEHP children, with the lowest income children (those without a co-pay) having a higher emergency room use rate than NC Health Choice children who are required to pay a co-pay.

The Task Force members identified three possible reasons why some families rely on emergency rooms inappropriately: (1) the parents are unable to take off from work to take their children to the doctor, so rely on the emergency room during non-work hours; (2) some families may lack

[24] Greenleaf-Bailey R. Women's and Children's Health, Division of Public Health. Presentation to the NC IOM NC Health Choice Task Force, October 8, 2002.

an ongoing relationship with a primary care provider, so rely on the emergency room when their child gets sick; and (3) lack of knowledge about the appropriate use of the emergency room. To address this problem, the SEHP has contracted with the Carolina Access II/III case managers in 11 counties, to help provide case management services to children who have used the emergency room at least one time in a six-month period. The program began on July 1, 2002 and costs the state approximately $23,000/month. The program is too new to evaluate.

The Task Force's top priority is to cover eligible children and to avoid a freeze on enrollment.

RECOMMENDATIONS

THE TASK FORCE'S TOP PRIORITY IS TO COVER ELIGIBLE CHILDREN AND AVOID A FREEZE ON ENROLLMENT.

To accomplish this goal, the Task Force developed options to maximize federal funds, ensure reasonable access to providers, maintain an adequate benefits package, and maximize the cost-effectiveness of the dollars spent by developing better systems to manage the care of enrolled children.

Specifically, the Task Force recommended:

1. ***The North Carolina General Assembly should appropriate, on a recurring basis, at least the current annual appropriations of $45.1 million for NC Health Choice***.

As a sign of its support for and commitment to a successful program that meets the health needs of almost 100,000 children, the North Carolina General Assembly increased the state appropriations for NC Health Choice to $45.1 million last year. Of this amount, $37.5 million was built into the base budget, and $7.7 million was a one-time non-recurring appropriation. The General Assembly should include the full $45.1 million in the base-budget. For every $1.00 the General Assembly appropriates, the federal government contributes an additional $3.00. Therefore, the increased state appropriations will not only help ensure the ongoing health insurance coverage for thousands of North Carolina children but will also ensure that additional federal dollars flow into the state. The remaining recommendations are built around the premise that the General Assembly contributes at least $45.1 million in program costs on an ongoing basis.

Young children, birth through five, should be moved into the Medicaid program. This will save the state approximately $1.7 million in SFY 04 and up to $7.4 million/year by SFY 07.

2. a) Move children birth through five with family incomes equal to or less than 200% of the Federal Poverty Guidelines into the Medicaid program. Counties should be held harmless for the costs of moving children into the Medicaid program.

b) Use part of the program savings from this move to increase the dental reimbursement rate in the Medicaid program for all children birth through age five.

Moving young children into Medicaid: The Task Force recommended that the General Assembly enact legislation to move the approximately 20,000 NC Health Choice children birth through age five with family incomes equal to or less than 200% of the Federal Poverty Guidelines into the Medicaid program. The Task Force recommended that counties be held harmless for the costs of NC Health Choice children who are moved into the Medicaid program, so they would not be required to pay the additional Medicaid costs for covering these children. Older children, six through 18, would remain in the NC Health Choice program administered by the State Employees' Health Plan.

Rationale: As described below, this recommendation will enhance the care of the younger children now covered by NC Health Choice at a lower cost than currently incurred, while still leaving the state the opportunity to reverse this change if it is determined to be advantageous sometime in the future.

Medicaid provides comprehensive health services to children. The state can move NC Health Choice children into the Medicaid program at a lower cost per child, and still use the enhanced SCHIP federal match rate. The federal State Children's Health Insurance law allows states to use the enhanced federal match rate to expand Medicaid as one of the SCHIP program options. States are also allowed to create combination SCHIP programs (i.e., part of the program is a Medicaid expansion, part remains a separate state program). With this change, North Carolina would join 16 other states that have a combination program. [25]

Many infants lose Medicaid coverage when they turn age one because of the differences in Medicaid income eligibility levels for infants (185% of the federal poverty guidelines) and toddlers (133% of the federal poverty guidelines). This sometimes causes a disruption in the coordinated care established with their primary care providers, as Medicaid requires enrollees to obtain care from their chosen primary care provider, whereas children in NC Health Choice can seek care from multiple providers. In

[25] CMS. State Child Health Insurance Program Plan Activity Map. Available on the Internet at: http://www.cms.gov/schip/chip-map.asp. (Accessed January 17, 2003)

addition, in many counties, there are Medicaid care coordinators (Health Check coordinators) who help to ensure that young children receive well-child screenings. The evaluation of the NC Health Choice program suggested that Medicaid children under age five who subsequently enrolled in NC Health Choice received fewer well-child check-ups once on NC Health Choice than when they were on Medicaid.[26] One of the possible reasons suggested for the decline in well-child visits in NC Health Choice is that the program lacks Health Check coordinators, who follow-up with families when they miss a well-child visit. Enrolling young children into Medicaid will help ensure that they receive preventive well-child check-ups.

Moving young children into Medicaid will ensure that all young children under age six with family incomes up to 200% of the federal poverty guidelines will continue to receive coverage even in budget shortfalls—as Medicaid is an entitlement program. In addition, covering children through Medicaid is less expensive than through the current NC Health Choice program. In SFY 04, children are expected to cost the equivalent of $102.20 in the Medicaid program (comprised of $435.54 for children under age one and $100.14 for children age one through five), compared to $153.72 in NC Health Choice. Medicaid's program costs are generally less expensive because the program has lower professional reimbursement rates. This proposal is expected to save the state approximately $1.7 million in SFY 04 and up to $7.4 million/year by SFY 07 (Table 8).

While this will result in decreased professional reimbursement to most providers, the providers on the Task Force were generally willing to accept this as a compromise because the youngest children would benefit from access to the Carolina Access Program, which emphasizes preventive care and links children to primary care providers. Further, these young children would be assured continuous enrollment as long as they meet program eligibility rules.

Further, the state maintains its ability to control overall program costs. The state still has the ability to "cap" program enrollment for the older children or to take other steps to reduce program expenditures if the program costs exceed budgeted amounts. Additionally, the state could move these children back into the traditional NC Health Choice program at a later date if it determined it was advantageous to do so.

Using savings to increase dental reimbursement rates in Medicaid: The Task Force recommended that the youngest children be rolled into the Medicaid program, and that part of the savings be applied to increase

[26] Slifkin RT, Freeman VA, Silberman P, Schwartz B. Assessing the Effects of the North Carolina Health Choice Program on Beneficiary Access to Care. Final Report. Submitted to the N.C. Division of Medical Assistance. Sept. 25, 2001.

Medicaid dental reimbursement rates for all Medicaid-eligible children birth through age five.

Medicaid dental reimbursement rates should be increased for young children to ensure that access to dental services is not impaired for the young children who will be moved into Medicaid.

Rationale: Members of the Task Force were concerned that moving NC Health Choice children (birth through age five) into Medicaid would lead to a significant reduction in access to dental services. Several studies have shown that families report much worse barriers in accessing dental services through the Medicaid program than in NC Health Choice.[27] This is due, in large part, to the differential payment rates paid to dentists under the two programs. The NC Health Choice program pays dentists, on average, about 100% of UCR rates, but Medicaid pays only between 40-60%, depending on the procedure. To address this problem, the Task Force recommended that the state use some of the savings from moving NC Health Choice children into Medicaid in order to increase the dental reimbursement rates up to 80% UCR for dental services provided to children birth through five. Providing preventive dental services to young children will help avoid expensive restorative care as the child gets older. The Task Force also recommended that the dental rates be increased for older children (See Recommendation # 8, below).

Even if the state increases the dental reimbursement rates for all Medicaid-eligible children age birth through five, there will still be an overall net savings to the state after the initial year from moving the NC Health Choice children into Medicaid. There will not be net cost savings in the first year if the dental reimbursement rates are increased beginning July 1, 2003 for all Medicaid children, but the savings from moving the NC Health Choice children into Medicaid do not occur until January 1, 2004 (because it will take six months to transition children into Medicaid). However, on an annualized basis thereafter, the net savings to the state from moving the youngest children into Medicaid and increasing the dental reimbursement rates to 80% UCR will run between $2.0 million and $4.3 million per year.

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[27] Freeman V, Slifkin RT, Schwartz R, Farel AM. A Cross Insurance Comparison of North Carolina Children with Special Health Care Needs. Preliminary Report. Slifkin RT, Freeman VA, Silberman P, Schwartz B. Assessing the Effects of the North Carolina Health Choice Program on Beneficiary Access to Care. Final Report. Submitted to the N.C. Division of Medical Assistance. Sept. 25, 2001. Mofidi M, Slifkin R, Freeman V, Silberman P. The Impact of a State Children's Health Insurance Program on Access to Dental Care. JADA. 2002;133:707-14.

Table 8
Medicaid Payment Levels for Children Birth through Five
EDS Fiscal Administration

	SFY04	SFY05	SFY06	SFY07
Children 0-5	**21,154**	**21,969**	**22,972**	**23,974**
Baseline SEHP pmpm	$153.72	$172.10	$192.68	$215.70
Total yearly costs if stayed in SEHP	$39,022,463	$45,370,375	$53,115,671	$62,055,152
Children 0-1	130	143	157	173
Medicaid pmpm	$435.54	$457.32	$480.18	$504.19
Total yearly costs in Medicaid (0-1)	$679,442	$784,756	$904,664	$1,046,703
Children 1-5	21,024	21,826	22,815	23,801
Medicaid pmpm	$100.14	$105.15	$110.40	$115.92
Total yearly costs in Medicaid (1-5)	$25,263,742	$27,538,849	$30,226,050	$33,108,952
Total Medicaid costs (children 0-5)	$25,943,184	$28,323,605	$31,130,715	$34,155,654
Total savings	$6,539,640*	$17,046,770	$21,984,956	$27,899,498
Total state savings	$1,704,230*	$4,456,026	$5,786,441	$7,351,518

Source: Division of Medical Assistance. Feb. 2003.
*Assumes 6 months savings in FY 04 because of 6 month start up time to implement. There will be an additional one-time administrative cost to transition children from the State Employees' Health Plan to Medicaid, and a small ongoing annual cost to calculate the county hold-harmless.

Table 9
Net State Savings by Moving Children Birth through Five into NC Medicaid, and Increasing Dental Reimbursement Rates

	SFY04	SFY05	SFY06	SFY07
NC Health Choice Children 0-5	21,154	21,969	22,972	23,974
State savings from moving children into Medicaid	$1,704,230*	$4,456,026	$5,786,441	$7,351,518
NC Health Choice additional costs from increasing Medicaid dental reimbursement rates	$533,978	$611,724	$659,482	$759,206
State costs	*$139,155*	*$159,905*	*$173,576*	*$200,051*
Medicaid children 0-5	275,360	299,095	325,151	353,775
Additional costs by increasing dental reimbursement rates**	$6,950,747	$8,328,267	$9,334,462	$11,203,306
*State costs from increasing dental reimbursement rates***	*$2,199,156*	*$2,629,859*	*$2,978,627*	*$3,605,224*
County costs from increasing dental reimbursement rates**	$388,086	$464,093	$525,530	$636,348
Total state costs by increasing dental reimbursement rates	**$2,338,310**	**$2,789,763**	**$3,152,202**	**$3,805,275**
Net savings (costs) to the state	**($634,080)****	**$1,662,262**	**$264,238**	**$3,546,243**

Source: Division of Medical Assistance. February 2003.
*Assumes 6 months savings in FY 04 from moving NC Health Choice children into Medicaid, because of 6 month start up time to implement. There will be an additional one-time administrative cost to transition children from the State Employees' Health Plan to Medicaid, and a small ongoing annual cost to calculate the county hold-harmless.
**Assumes that increased dental rates will be effective July 1, 2003.

3. ***Enroll NC Health Choice children into Carolina Access II/III as it is expanded across the state.***

Rationale: The Task Force recommended that all children in the NC Health Choice program be enrolled in Carolina Access II/III as it is expanded across the state. This model is built around provider-led community networks that include, at a minimum, local primary care providers, a local hospital, Department of Social Services (DSS), and the health department. Each network is responsible for population health management, identifying individuals with certain high-cost or complex health conditions in need of case management. Access II and III networks are paid $2.50 pmpm (in addition to the $2.50 pmpm paid to primary care providers to coordinate care), which must be used for managed care activities such as hiring care coordinators, conducting risk assessments, and operating targeted disease and care management initiatives.

This model offers two benefits over the traditional NC Health Choice program: it links children to a primary care provider, and has a well-developed system of disease management and care coordination to help manage the care of children with complex or chronic health conditions. The Task Force recognized that this program is likely to increase costs initially, but should help reduce costs later by improving the health of children. Initial data from Carolina Access II/III showed improved health outcomes and significant program savings among children with asthma. In SFY 2000, hospital emergency room visit costs pmpm was $3.41 in Access II/III counties compared to $4.36 in Access I counties.[28] The average asthma episode cost was $687 in Access II/III counties compared to $853 in Access I counties. Children with asthma were also more likely to receive corticosteriods to control their asthma in Access II/III sites (67%) compared to Access I sites (58%). The cost of enrolling NC Health Choice children into Carolina Access II/III would be as follows (Table 10):

NC Health Choice children should be enrolled in Carolina Access II/III. Carolina Access II/III helps to link children to primary care providers, and offers a well-developed system of disease management and care coordination to help manage the care of children with complex or chronic health conditions. This should produce long-term cost savings by improving the health of children, reducing the use of the emergency room and the number of inpatient hospitalizations.

[28] NC Office of Research, Demonstrations and Rural Health Development. NC's Community Care Program (Access II and III). Frequently Asked Questions. May 2001.

Table 10
Administrative Costs Associated with Moving NC Health Choice Children into Access II/III Case Management Model

	SFY04	SFY05	SFY06	SFY07
Total membership (6-18)	84,614	87,877	91,887	95,897
Percent of eligibles enrolled	72.7%	100%	100%	100%
Children in counties with Access II/III	61,514	87,877	91,887	95,987
Access admin. entity fee ($2.50 pmpm paid to network)	$1,845,431	$2,636,310	$2,756,610	$2,879,610
Access case management fee ($2.50 pmpm paid to provider)	$1,845,431	$2,636,310	$2,756,610	$2,879,610
Costs	$3,690,863	$5,272,620	$5,513,220	$5,759,220
Savings from elimination of existing case management fee ($23,000/month)	-$276,000	-$276,000	-$276,000	-$276,000
Total net costs	$3,414,863	$4,996,620	$5,237,220	$5,483,220
State net costs	$889,913	$1,306,116	$1,378,436	$1,444,828

Source: Division of Medical Assistance. February 2003.

Until Carolina Access II/III is available throughout the state, the State Employee's Health Plan should work with the Carolina Access II/III Clinical Director's Group to develop a system to target the high cost children for intervention, i.e., the 4,005 children that are using 42% of the program's resources.

4. ***Develop a differentiated prescription drug co-payment to encourage the use of generic drugs***. The co-payment structure should be higher for children with family incomes greater than 150% of the federal poverty guidelines, and less for children with families between 100-150% of the federal poverty guidelines.

Under the current co-payment structure, children with family incomes in excess of 150% of the federal poverty guidelines pay $6 per prescription, regardless of whether the drug is generic or a brand-name. There is no

incentive for either physicians to prescribe or families to use generic medications. Families with lower incomes pay nothing for their medications.

The Task Force recommended a two-tiered co-payment to encourage physicians to prescribe and families to request generic drugs (Table 11).

The Task Force recommended a two-tiered drug co-payment to encourage physicians to prescribe and families to request generic drugs. This would result in a savings to the state of approximately $250,000 in SFY 04.

Table 11
Prescription Drug Co Payments by Family Income

	Current	**Proposed**
Family Incomes <= 150% FPG	No copayments	$1 generic or brand when no generic equivalent is available $3 brand when generic substitution available
Family Incomes >150% FPG	$6 per script	$1 generic or brand when no generic equivalent is available $10 brand when generic substitution available

Data suggests that these additional co payments will result in $242,828 savings to the state in SFY 04, and $371,144/year by SFY 07 (Table 12)

Table 12
Cost Savings from Recommended Prescription Drug Co Payment Proposal

	SFY04	**SFY05**	**SFY06**	**SFY07**
Membership	84,614	87,877	91,887	95,897
Baseline pmpm	$153.72	$172.10	$192.68	$215.70
Changes in copayment	$152.78	$171.07	$191.55	$214.45
Savings $ pmpm	-$0.94	-$1.03	-$1.14	-$1.25
Savings % pmpm	-0.59%%	-0.58%	-0.57%	-0.56%
Total yearly savings	$922,599	$1,053,585	$1,211,351	$1,390,051
State yearly savings*	$240,429	$275,407	$318,828	$366,278

Source: AON Consulting, under contract to the State Employees' Health Plan provided data on the savings pmpm. Analysis by the Division of Medical Assistance. February 2003.

Reducing the prescription drug dispensing fee would lead to an approximately $500,000 state savings in FY 04.

5. ***Reduce the prescription drug dispensing fee in the NC Health Choice program to $1.50 per prescription.***

Rationale: Currently, the NC Health Choice program pays providers the same fees as paid under the State Employees' Health Plan—with one exception. Pharmacists are paid a much higher dispensing fee under the NC Health Choice program than they are paid under the State Employees' Health Plan. NC Health Choice program pays pharmacists $4.00 to dispense brand name drugs, and $5.60 to dispense generic drugs. The State Employees' Health Plan pays $1.50 dispensing fee per prescription. The Task Force recommended that the NC Health Choice dispensing fee be changed to match the dispensing fee under the State Employees' Health Plan. This is expected to save the state approximately $500,000 in SFY 04 for the approximately 85,000 children ages 6-18 (Table 13).

Table 13
Cost Savings from Recommended Changes in the Drug Dispensing Fee

	SFY04	SFY05	SFY06	SFY07
Membership	84,614	87,877	91,887	95,897
Baseline pmpm	$153.72	$172.10	$192.68	$215.70
Changes in dispensing fee pmpm	$151.81	$169.84	$190.02	$212.55
Savings $ pmpm	-$1.91	-$2.26	-$2.66	-$3.15
Savings % pmpm	-1.20%	-1.27%	-1.33%	-1.41%
Total yearly savings	$1,876,470	$2,303,255	$2,833,510	$3,503,981
State yearly savings*	$489,008	$602,071	$745,780	$923,299

Source: AON Consulting, under contract to the State Employees' Health Plan provided data on the savings pmpm. Analysis by the Division of Medical Assistance. February 2003.

6. ***The current appropriations language prohibiting the NC Department of Health and Human Services from transferring other departmental funds into NC Health Choice should be repealed.***

Rationale: One of the biggest problems facing the NC Health Choice program is that the Department of Health and Human Services has little flexibility to address mid-year budget shortfalls. Under the current program design, DHHS has primary responsibility for eligibility but not for professional reimbursement or utilization controls. When faced with a budget shortfall in SFY01, the Department was forced to close enrollment.

In the past, the General Assembly prohibited DHHS from transferring other Departmental funds to help fund the NC Health Choice program. Last year, however, the General Assembly gave the Department limited authority to transfer $5 million dollars of other program funds into NC Health Choice in the event of a budget shortfall. Similar restrictions do not apply to other Departmental programs. To provide additional flexibility to the Department to avoid freezing enrollment, the Task Force recommended that the prohibition on interdepartmental transfers be repealed.

The NC Department of Health and Human Services needs other tools so that it does not need to freeze the program mid-year if enrollment exceeds expectations.

7. ***The General Assembly should create a NC Health Choice trust fund***.

Rationale: The Task Force recommended that the General Assembly create a NC Health Choice Trust Fund, as it has with Medicaid and the State Employees' Health Plan, the state's two other publicly-funded health insurance programs. Any unspent state appropriations should be placed into the NC Health Choice trust fund at the end of the fiscal year rather than revert to General Funds. Funds placed in this trust fund (if any) will help ensure that the state has available funds to address unanticipated growth in the NC Health Choice program, and that the state has funds to use as match should any additional federal funds be redistributed to North Carolina.

8. Increase the Medicaid dental reimbursement rates up to 80% of UCR.

The Task Force recommended that Medicaid dental reimbursement rates be increased so that all Medicaid eligible children can access dental services.

While not specifically part of its original charge, the Task Force members thought it was important to address the continuing problem of lack of access to dental services in the Medicaid program. In 1999, the NC Institute of Medicine studied the problems that Medicaid recipients and other low-income people have in accessing dental services. At that time, dentists were reimbursed 62% of their UCR rates for the 44 most common procedures for children, and 42% of UCR for other procedures.[29] These rates did not cover the operating costs of most of the private dentists. As a result of the low reimbursement rates, many dentists have been unwilling to participate in Medicaid, leading to ongoing access barriers for Medicaid recipients. Children in NC Health Choice have a far easier time accessing dental services than do children in Medicaid. Task Force members thought it was important to ensure access to dental services for all children—not just those on NC Health Choice. As a result, the Task Force recommended that the dental rates paid to dentists in Medicaid be increased to 80% UCR. Some of the additional costs associated with this

[29] NC Institute of Medicine Task Force on Dental Care Access. Report to the North Carolina General Assembly and to the Secretary of the North Carolina Department of Health and Human Services. April 2000.

proposal can be offset by reducing the current NC Health Choice reimbursement rate to 80% UCR (Table 14), however the cost savings were not available at the time this report was written.

Table 14
Costs of Increasing Dental Reimbursement Rates for Medicaid Children (6-20)
Up to 80% UCR

	SFY 04	SFY 05	SFY 06	SFY 07
Medicaid children 6-20	372,826	405,835	442,118	482,163
Additional total costs by increasing dental reimbursement rates	$22,761,172	$25,108,532	$27,697,975	$30,554,467
Additional state costs by increasing dental reimbursement rates	$7,201,436	$7,928,647	$8,838,424	$9,832,427
Additional county costs by increasing dental reimbursement rates	$1,270,842	$1,399,173	$1,559,396	$1,735,494

SUMMARY OF FISCAL AND COST-EFFECTIVENESS IMPLICATIONS

The Task Force was charged with examining options to ensure the long-term financial viability of the program, to ensure that eligible children can continue to receive coverage and that the program will not be capped. The legislature specifically requested the Task Force to study professional reimbursement rates. The Task Force members took this charge seriously and developed a set of recommendations that would help reduce program costs and maximize federal funds, while at the same time maintaining an adequate benefits package. Much of the savings come from targeted reductions in professional reimbursement, but in a manner that will ensure reasonable access to providers. These targeted professional reimbursement cuts include the following:

1) ***Reductions in the State Employees' Health Plan professional reimbursement rates***. The State Employees' Health Plan will be implementing a 3.3% rate reduction beginning April 1, 2003. This will save the state $1.4 million in NC Health Choice program costs in SFY 04.
2) ***Cuts in provider reimbursement rates by moving children birth through five from NC Health Choice into Medicaid.*** Primary care providers will experience a cut in professional reimbursement from approximately 123% of Medicare rates to 95% of Medicare rates. Specialists will experience a cut in professional

reimbursement from approximately 146% of Medicare rates to 95%. Hospital inpatient services will be reduced from approximately 163% of Medicare rates to 84%. Moving children birth through five into Medicaid will save the state approximately $1.7 million is SFY04, increasing to $7.4 million in SFY07, although part of these savings will be offset in order to increase access to dental services.

3) ***Potential of further rate reductions from Medicare***. Because the Medicaid physician reimbursement rates are currently tied to Medicare, any reduction in the Medicare rates would lead to a reduction in the Medicaid rates. The federal government is currently scheduled to reduce the physician reimbursement rates in Medicare by approximately 5% in March 2003. If the Division of Medical Assistance continues to tie Medicaid reimbursement rates to Medicare, this will translate to an additional 5% reduction in the rates paid to physicians in the Medicaid program.
4) ***Reductions in the pharmacy dispensing fee***. Reducing the prescription drug dispensing fee from $4.00 for brand name drugs/$5.60 for generics down to $1.50 per prescription (the same amount paid by the State Employees' Health Plan) will save the NC Health Choice program $493,887 in state costs in SFY 04.

The Task Force also included several recommendations to improve the cost-effectiveness of the program. Specifically, the Task Force recommended:

1) ***Enrolling NC Health Choice children into Medicaid's Carolina Access II/III as it is expanded across the state.*** Carolina Access II/III provides better management of children with high-cost, complex or chronic health conditions. Young children will automatically be enrolled in Carolina Access II/III when they are moved into the Medicaid program. The Task Force recommended that the State Employees' Health Plan enroll the older children (6-18) into Carolina Access as the program expands across the state. While this will initially lead to greater administrative costs in the program, it should lead to long-term savings. Managing the care of children with chronic or complex health conditions should lead to lower hospitalizations, reduced use of the emergency room, better disease management, and lower overall costs, as it did initially in the Medicaid program.
2) ***Additional co-payments for brand name drugs (when a generic equivalent is available).*** The Task Force recommended that the co-payments on prescription drugs be increased to encourage physicians to prescribe and families to ask for generic drugs. The additional copayments will save the state $242,828 in SFY 04 by reducing the number of brand name drugs that are prescribed.

3) ***Improving access to dental services***. The Task Force also recommended that Medicaid dental reimbursement rates for all children be increased, so that children will be able to access dental services. This will lead to higher costs initially, but if children can be provided with preventive services, it should offset expensive restorative costs in the future.

The Task Force recommendations also include additional responsibilities for the families. First, families are expected to pay higher co-payments when they request brand-name drugs (if generic equivalents are available). In addition, as children are enrolled in Carolina Access, they will be required to select a primary care provider who will help manage their care. Under the existing system, children can go to any provider who is willing to accept NC Health Choice. Under Carolina Access II/III, the child must coordinate care through his or her primary care provider. While providing better care coordination, this system provides some limits on choice of providers.

The Task Force recommended a series of changes to the NC Health Choice program which should lead to lower overall program costs (Table 15):

Table 15
Overall NC Health Choice Program Costs After Implementation of Task Force Recommendations

	SFY 04	SFY 05	SFY 06	SFY 07
Total NC Health Choice costs (if no changes made) (Table 2)	$204,054,707	$236,998,127	$277,175,177	$323,614,273
SEHP professional reimbursement reduction (Table 6)	-$5,386,631	-$6,340,003	-$7,501,528	-$8,893,293
Savings from moving children (0-5) into Medicaid (Table 8)	-$6,539,640	-$17,046,770	-$21,984,956	-$27,899,498
Costs of increasing dental reimbursement rates for NC Health Choice children in Medicaid (Table 9)	+$533,978	+$611,724	+659,482	+759,206
Enrolling NC Health Choice children into Carolina Access II/III* (Table 10)	+$3,414,863	+$4,996,620	+$5,237,220	+$5,483,220
Savings from changes to prescription drug co-payments (Table 12)	-$922,599	-$1,053,585	-$1,211,351	-$1,390,051
Savings from reductions in the dispensing fees (Table 13)	-$1,876,470	-$2,303,255	-$2,833,510	-$3,503,981
Revised NC Health Choice program costs	$193,278,208	$215,862,857	$249,540,534	$288,169,876
State share (% Total Costs)	26.06%	26.14%	26.32%	26.35%
State share	$50,368,301	$56,426,551	$65,679,068	$75,932,762
State ongoing appropriations	$45,058,178	$45,058,178	$45,058,178	$45,058,178
Additional state appropriations needed for NC Health Choice	**$5,310,123**	**$11,368,373**	**$20,620,890**	**$30,874,584**
Additional state appropriations needed to increase dental reimbursement to 80% UCR (Medicaid children 0-5)(table 9)	$2,199,156	$2,629,859	$2,978,627	$3,605,224
Additional state appropriations needed to increase dental reimbursement to 80% UCR (Medicaid children 6-20)(table 14)	$7,201,436	$7,928,647	$8,838,424	$9,832,427
Total state appropriations needed to implement all Task Force recommendations	**$14,710,714**	**$21,926,878**	**$32,437,941**	**$44,312,236**

* This will lead to an increase in administrative costs, but should lead to decreases in programmatic costs after implementation from improved health, reduced use of the emergency room and fewer hospitalizations.

The NC Health Choice program is an exemplary program that has provided health insurance to thousands of needy children in the state. This program is particularly important now, as rising health insurance premiums have made health insurance coverage unaffordable to many working families in the state. Studies of the NC Health Choice program have consistently shown that access to needed health services improves once children enroll in the program. Not only does access to care improve, but parents also report that their children's health status improved after enrolling in NC Health Choice. The program has made a positive impact on the health of North Carolina children.

As parents expressed in a series of recent focus groups[30] about the program:

> *I was on welfare for so long. I said if God would bless me with a job, I'd make sure my kids are taken care of. It was hard to seek help again…I said I wouldn't go back to Social Services, but then the kids got sick and I got to where I couldn't afford insurance. My income is above the level for Medicaid, so this program helps me.*
>
> *(NC Health Choice) is a blessing…we all work. We're not lazy but we're borderline…(we either) get Medicaid or NC Health Choice or we have no insurance.*
>
> *There's so many of us that fall into that middle income range…not poor enough (for Medicaid) but not rich enough (for private insurance).*

[30] Silberman P, Walsh J, Slifkin R, Poley S. The North Carolina Health Choice Enrollment Freeze of 2001. Kaiser Commission on Medicaid and the Uninsured. January 2003.

APPENDIX A

Options Considered but Rejected

The Task Force considered other options to reduce program expenditures, but after careful reflection, **rejected** these options. Specifically, the Task Force considered moving the NC Health Choice program into a BCBS PPO payment structure, and imposing higher co-payments on the use of the hospital emergency room.

1. ***Moving the NC Health Choice program into a BCBS PPO payment structure.***

The Task Force considered the option of moving the NC Health Choice program into a Preferred Provider Organization (PPO) payment structure. PPOs reduce medical expenditures by negotiating lower payment rates with providers. The providers, who are willing to accept lower payment rates, are part of the PPO's "network" of providers. Patients may choose any health care provider, but they will have to pay additional money out-of-pocket if they use a provider who is not part of the PPO network ("out-of-network provider"). Typically, PPOs charge higher co-payments, coinsurance and/or deductibles if a person uses an out-of network provider. Additionally, out-of-network providers who are not part of the network are allowed to "balance-bill" the patient for any charges that remain after the insurance company pays the portion of the bill it is willing to pay.

Blue Cross Blue Shield of North Carolina (BCBSNC) conducted an analysis to determine whether the providers who participated in NC Health Choice were also part of the BCBSNC PPO network. In 2002, approximately 95% of the NC Health Choice claims for primary care were to providers who participated in the BCBSNC PPO network. Only about 82% of the claims for specialty care were paid to providers who also participated in the BCBSNC PPO network. While an analysis of claims is not a direct proxy for provider participation—it does give an indication of the percentage of NC Health Choice families who may experience disruption in their relationship with providers if the program became part of the BCBSNC PPO payment structure. Roughly, 5% of the primary care providers and 20% of the specialists who currently participate in NC Health Choice do not participate in the PPO. If families wanted to continue their relationship with these providers, they would be required to pay more out of pocket, in both increased co-payments and "balanced billing." Because of the relatively low family incomes of the NC Health Choice families, the Task Force was concerned that the additional costs the families would incur if they wanted to maintain their relationship with the out-of-network providers would be prohibitive—forcing families to change providers. The Task Force was particularly concerned about the impact this may have for children with special health care needs, as these children are more likely to rely on specialists for care. Maintaining a continuous, on-going relationship with a provider is particularly important

for children with complex or chronic health problems. In addition, Task Force members expressed concern that moving to a PPO network would cause problems for families in rural areas—where there may be few in-network providers available. Therefore, after careful consideration, this option was rejected.

2. Adopt higher co-payments for use of the hospital emergency room.

Currently, the children with family incomes greater than 150% of the federal poverty guidelines pay a $20 co-payment for use of the emergency room (this is waived if the child is admitted). Children with lower family incomes do not currently pay a co-payment if they visit the emergency room. Last year, the NC General Assembly considered the possibility of raising the current emergency room co-payments to $30 for families with incomes greater than 150% of the federal poverty guidelines, and $10 for families with incomes that are equal to or less than 150%. According to AON consulting, actuaries for the State Employees' Health Plan, this increased co-payment may be expected to reduce emergency room utilization by 5%, leading to modest state savings of approximately $100,000 in SFY 04. This assumes that hospitals actually try to collect the co-payment. However, hospitals reported that they were likely to waive the co-payment rather than try to collect it, as it would probably be more costly to try to collect the co-payment than to waive it. Because so few families would likely pay the co-payment, charging the emergency room co-payment would effectively result in a cut in hospital reimbursement rates. If emergency room co-payments were increased (making it more cost-effective to try to collect), then the higher co-payments could deter families from seeking care from the emergency room in life and death emergencies.

The State Employees' Health Plan has already developed a system to try to discourage unnecessary use of the emergency room. As noted earlier in the report, the SEHP has contracted with Carolina Access II/III in 11 counties to pay for case management services to work with families who use the emergency room inappropriately. The Task Force members thought the state should wait to determine whether this approach helps reduce unnecessary utilization of the emergency room before trying to raise the hospital emergency room co-payments.

If, at some later date, the legislature was interested in testing the impact of higher co-payments on use of the emergency room, the Task Force members thought this should be done through a pilot program (like the emergency room case management model currently being implemented in 11 counties). Hospitals should be paid their full reimbursement rates. The co-payments, if collected, would help offset the additional costs that the

hospitals incur in trying to collect the co-payments. Hospitals indicated a willingness to try to collect emergency room co-payments as part of a pilot program, to determine if the modest co-payments had any deterrent effect on the unnecessary use of the emergency room. However, the Task Force did not recommend immediate implementation of this pilot until the state obtains results from the Access II/III emergency room case management initiative.