New Opportunities to Expand Health Insurance Access to Low Income North Carolinians

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Issue Brief

North Carolina Institute Of Medicine

As of April 6, 2017 there are three proposed plans for expanding access to health insurance for poor and near poor residents of North Carolina: the Alternative Benefit Plan State Plan Amendments (Medicaid Expansion) submitted to the Centers for Medicare and Medicaid Services by Governor Cooper's administration; Senate Bill 290 sponsored by nine Democrat state senators; and House Bill 662 sponsored by four Republican state representatives.

The three plans are very similar and present an opportunity for partnering across party lines, chambers, and branches of government to increase North Carolinians' access to health insurance.

Any of the three proposed plans would benefit the health and well-being of the approximately 375,000-550,000 North Carolinians who may be eligible for health care coverage under these expanded access options.

The North Carolina Institute of Medicine is monitoring and studying proposals to expand Medicaid in North Carolina, with an eye towards the impact on the health and well-being of North Carolinians. In this brief, we compare and contrast the three current proposals to expand health insurance options to low income North Carolinians.

Medicaid in North Carolina

Currently in North Carolina, adult eligibility for Medicaid is limited to:

- Disabled adults
- Working parents with incomes below 49% of the federal poverty levels (FPL), or $10,210 for a family of three
- Nonworking parents with incomes below 35% of FPL, or $7,147 for a family of three
- Pregnant women with incomes up to 185% of FPL, or $37,777 for a family of three

Childless, non-disabled adults cannot qualify for Medicaid in North Carolina under the current eligibility criteria. All three Medicaid expansion proposals increase eligibility for adults ages 19 to 64.

The Affordable Care Act (ACA), passed in 2010, provided an option for states to expand Medicaid to individuals in households earning up to 133% of the federal poverty guidelines.[a,b] The federal government typically funds 57% of Medicaid costs with states covering the rest of the cost of care (this is known as the Federal Matching Assistance Percentage or FMAP).[1] Under the ACA's Medicaid expansion, the federal government covered 100% of the cost of those newly eligible recipients from 2014-2016 with the percentage gradually declining to 90% of the cost of new eligible in 2020. So far, thirty-one states and the District of Columbia have expanded Medicaid.

In 2013, the North Carolina General Assembly passed legislation preventing the state from expanding Medicaid unless directed to do so by the General Assembly.[c] In January 2017, newly elected Governor Cooper declared his intention to expand Medicaid and filed an Alternative Benefit Plan State Plan Amendments (Medicaid Expansion) with the Centers for Medicare and Medicaid Services. In turn, the Senate leader, Phil Berger, and state House Speaker Tim Moore filed a lawsuit to prevent Governor Cooper from expanding Medicaid. While the lawsuit is still pending, three proposals have moved forward to expand Medicaid coverage.

Comparison of Plans

All three plans would extend health care coverage through Medicaid to adults up to 65 with incomes below 133% FPL. In 2017, the FPL for a single adult household is $12,060 rising to $24,600 for a family of four. The benefit package would not be traditional Medicaid. Instead, coverage offered through expansion would be equal to the Blue Cross and Blue Shield "Blue Options" plan, which is the base benchmark plan that defines Essential Health Benefits for products in the North Carolina Health Insurance Marketplace.

a In 2017, the FPL for a single adult household is $12,060 rising to $24,600 for a family of four.
b The language of ACA specifies that childless adults are Medicaid-eligible with "modified adjusted gross income" (MAGI) at or below 133 percent FPL. ACA's MAGI calculation is based on adjusted gross income (AGI) as defined in the Internal Revenue Code, §36B(d)(2). However, §2002(a)(14)(I)(i) of ACA adds a five percentage point deduction from the FPL-- one of several ways in which the AGI is "modified." With this five percent disregard, the Medicaid eligibility threshold is effectively 138 percent FPL. In this report, we use 133% when stated in law but 138 when available in our analysis.

c North Carolina General Assembly. No N.C. Exchange/No Medicaid Expansion. Senate Bill 4. Session 2013. March 6, 2013.

Expansion would be largely funded by the federal government (94% of costs), under the funding scheme laid out in the Affordable Care Act. The total cost for providing this insurance option to between 375,601[d2] and 468,000[e] people would be between $1.54 billion and $1.9 billion.[f3] The FMAP or federal share for this program under the ACA is 94% in 2018, 93% in 2019, and 90% in 2020 and beyond. In all three plans, state funds for expansion would primarily come through a new "assessment" on hospitals.

Table 1: Comparison of North Carolina Medicaid Expansion Proposals

	Alternative Benefit Plan State Plan Amendments[g]	**Senate Bill 290: Medicaid Expansion/Healthcare Jobs Initiative[e]**	**House Bill 662: Carolina Cares[h]**
Primary Sponsors	Governor Roy Cooper	Senator Ben Clark, D- 21st District; Senator Angela Bryant, D - 4th District	Representative Lambeth, R-75th District; Representative Murphy, R-9th District; Representative Dobson, R-85th District; Representative While, R-26th District
Benefit Package	Blue Cross and Blue Shield "Blue Options" plan, which is the base benchmark plan that defines Essential Health Benefits for products in the Marketplace in addition to non-emergency medical transportation and Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services.		
Administration	Division of Medical Assistance, NC DHHS	Division of Medical Assistance, NC DHHS	Administered by pre-paid health plans
Program Requirements	Income eligibility only	Income eligibility only	Requires work or work promoting activities (exceptions apply).
Cost to Enrollee	None	None	Participant contribution of an annual premium of 2% of annual household income (exceptions apply)
Funding (state and federal amounts)	Federal funds: DHHS must seek the highest federal financial participation percentage available State Funds: local match and expenditure savings. Required 5% local match contributed by hospitals. Estimate between $100 million and $150 million in the first year.	Federal Funds for Administration: FY 2017-2018 $29,518,80 Federal Funds for Service: FY 2017-18: $1,245,420,164; FY 2018-19: $3,468,254,700 State Funds for Administration: FY 2017-18: $27,481,199 State funds for Services FY 2017-2018: $114,848,013 from Medicaid Expansion Assessment (on hospitals), $6,731,823 (from savings to other programs) State funds FY 2018-19: $273,397,475 from the Medicaid Expansion Assessment and $21,347,825 in from savings to other programs.	Federal funds: DHHS must seek the highest federal financial participation percentage available State funds: funded through health care-related assessments, including, but not limited to, hospital assessments. Participant contributions: monthly premium payments of 2% of income.
Proposed Timeline	Start date of January 1, 2018	Start date of January 1, 2018	Department of Health and Human Services design proposal to NCGA by January 1, 2018

d NCIOM Calculated using 2015 American Community Survey estimate of the uninsured population with incomes below 133% FPL who are US citizens.
e North Carolina General Assembly. Medicaid Expansion/Healthcare Jobs Initiative. Senate Bill 290. Session 2017. March 15, 2017.
f Calculated cost per beneficiary. In 2016, the cost per adult (non-pregnant, non-aged, blind, or disabled) was $4093.
g S 32: Eligibility Groups- Mandatory Coverage Adult Group. NC Medical Assistance Health and Human Services. https://ncdma.s3.amazonaws.com/s3fs-public/S32final.pdf. Accessed April 11, 2017.
h North Carolina General Assembly. Carolina Cares. House Bill 662. Session 2017. April 6, 2017.

Alternative Benefit Plan State Plan Amendments

After taking office in January 2017, Governor Roy Cooper submitted a State Plan Amendment proposal to the federal Centers for Medicare and Medicaid Services. The plan laid out by Governor Cooper included a start date of January 1, 2018 and has expansion administered by the Division of Medical Assistance.[4]

Senate Bill 290

In March 2017, a bill was introduced in the General Assembly to address Medicaid expansion. Senate Bill 290, sponsored by Senators Clark and Bryant, is very similar to the plan outlined by Governor Cooper but provides additional details on funding. The bill provides the most detailed account of the costs associated with Medicaid expansion (see Table 1). All three proposals are likely to have similar costs.[e]

Program administration is expected to require $27 million in state funds the first year and $30 million in federal funds. Service costs are expected to total $1.37 billion in the first year, with the bulk ($1.25 billion) coming from federal funds. State funding would come primarily from a Medicaid Expansion Assessment on hospitals, which is expected to raise $115 million in the first year. The remaining state funding would come from savings to the inmate health program and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, ($6.7 million). It is important to note that cost estimates for the first year are for a half year of the program (January 2018-June 2018) and costs are higher in subsequent years.[e] Senate Bill 290 would extend eligibility to approximately 468,000 North Carolinians.[e]

House Bill 662

On April 6, 2017, a bill was filed by four North Carolina State Representatives to increase the options for participating in health insurance for low income North Carolina Residents. House Bill 662, sponsored by Representatives Lambeth, Murphy, Dobson, and White, is similar to the other two proposals but has some key differences in program requirements, program administration, and start date (see Table 1).[h]

House Bill 662 proposes creating a new program, Carolina Cares, which would create a separate insurance product managed by the North Carolina state Medicaid agency (and eventually contracted under capitated rates to North Carolina's Pre-Paid Health Plans). This proposal pairs Medicaid expansion with Medicaid reform in North Carolina and does not lay out a start date. Instead, it specifies that the North Carolina Department of Health and Human Services will submit a plan for Carolina Cares by January 1, 2018.[h]

Unlike the other two proposals, House Bill 662 lays out additional program requirements including that beneficiaries work or be engaged in work promoting activities unless special exceptions apply and requires participant contribution of an annual premium, billed monthly, of 2% of annual household income with certain exceptions. The bill would also require co-payments, establishment of wellness and preventive care activities, and defined evaluation of health outcomes and quality of provided care. Premium Requirements of 2% of household income apply with the follow exceptions: household income below 50% of federal poverty level, medical hardship, financial hardship, member of federally recognized tribe, or a veteran in transition actively seeking employment. In addition, participants are required to be employed or engaged in activities to promote employment with the following exceptions: caring for a dependent minor child, disabled adult child, or a disabled parent; engaged in active substance abuse treatment, or medically frail.

Lastly, while all three proposals lay out similar state funding mechanisms (namely the assessment on hospitals), House Bill 662 *requires* that no new state funds be used to cover the usual state share of the cost of serving the new beneficiaries. In addition to federal funds and healthcare related assessments, Senate Bill 662 will by partially funded through premium payments by consumers.[i] House Bill 662 explicitly states that if participant contributions and the health care assessments (on hospitals) are not able to cover the costs of the program, the program shall not be implemented. In addition, the bill explicitly states that the State shall have the option to end Carolina Cares if the federal reimbursement rate is ever reduced below 90%.[h]

House Bill 662 would extend eligibility to approximately 375,000 uninsured North Carolinians in addition to the opportunity to enroll in Carolina Cares for insured North Carolinians with modified adjusted gross incomes between 100 and 138% of the Federal Poverty Level. Most of these consumers have extensive premium support from the subsidies under the Affordable Care Act.[h] Some of these residents may not work, be engaged in work promoting activities, or meet one of the listed exceptions to the work requirement. Such residents would be ineligible for Carolina Cares. Currently 60% of uninsured North Carolinians below 138% of the federal poverty level are employed.[2] It is likely that many more are engaged in work promoting activities or meet one of the exceptions to the work requirements.

Medicaid Expansion in Other States

Since the passage of the Affordable Care Act (ACA) in 2010, 31 states and D.C. have adopted Medicaid expansion. Models of Medicaid expansion vary between states, but most have done straight expansions without additional program requirements, similar to the proposals from Governor Cooper and Senate Bill 290.

Among states that have expanded Medicaid, 18.9% of non-elderly adults with incomes at or below 138%

i A precise estimate of the total contribution from participants will require further analysis. Given hardship exemptions (household income <50%, medical hardship, financial hardship, member of federally recognized tribe, veteran in transition actively seeking employment), premium payments should be expected for perhaps half of the new participants. An individual with an income of $12,060 per year (100% FPL) would contribute $252 per year or $21 per month. If half of new participants contributed $21 per month, that would cover about 3.0% of the cost of the new program

FPL remained uninsured in 2015. In non-expansion states, this figure was 35.2%. Overall, states that expanded Medicaid saw a 44.3% reduction in uninsured non-elderly adults in this income group; states that did not expand saw a reduction of 20.9%.[5]

No state has implemented Medicaid expansion exactly as laid out in House Bill 662. However, Indiana implemented a Medicaid expansion plan similar in structure to the Carolina Cares bill. Beginning in 2015, Healthy Indiana Plan (HIP) 2.0 was implemented through a Medicaid waiver. Similar to House Bill 662, Indiana implemented premiums and limited co-pays for enrollees in HIP 2.0. Under HIP 2.0, most beneficiaries pay premiums of 2% of their income. Beneficiaries pay their premiums into a POWER (Personal Wellness and Responsibility) account, and payments for care come from this account. The plan also provides for reduced premiums for those who receive preventive care.[6,7,8]

Early analysis of HIP 2.0 shows that even low premiums can be difficult for many potential beneficiaries, and that frequent changes in beneficiaries' income amounts leads to challenges in accurate assessment of premiums and payments. It is also unclear how the health savings account and wellness incentive models are impacting costs and health outcomes for beneficiaries, and 84% of people who received reduced benefits after failing to pay premiums reported confusion about the program and payment requirements.[8] However, despite challenges, HIP 2.0 has increased coverage to many in Indiana who were unable to receive it prior to its implementation.[6,7,8]

To date, no state has implemented a work requirement for Medicaid participation as part of an 1115 waiver. Several states have proposed such requirements but none have been approved by the Centers for Medicare and Medicaid Services. However, on March 14, 2017, a letter to state governors from the Centers for Medicare and Medicaid Services indicated it will use the 1115 waiver to approve provisions related to employment. Since that time, four states have submitted 1115 waivers including work requirements. An addition, three states have voluntary job training and referral programs associated with Medicaid but not part of 1115 waivers.[9]

North Carolina Institute of Medicine Recommendations:

Upon passage of the Affordable Care Act in 2010, the North Carolina Institute of Medicine, in partnership with the North Carolina Department of Health and Human Services, convened a series of Health Reform Workgroups to examine the ACA provisions and their impact on the state. The Task Force recommendations included an expansion of Medicaid eligibility through the ACA, based on projections of anticipated costs to the state, job creation, and new tax revenues. In addition, the Task Force recommended simplified eligibility and enrollment processes in order to reduce administrative burdens to applicants and state agencies, including prevention of coverage gaps due to changes in participants' income. The Task Force also recommended the development of a broad education and outreach campaign on new insurance options. This campaign would help newly-eligible participants, health care providers, and administrators understand coverage eligibility, payment requirements, and relevant penalties.

As North Carolina examines the three current expansion proposals, policymakers and state agencies should look to the experiences of other states with regards to administrative burden, confusion about eligibility and payments, and other relevant learnings, and consider ways to adopt the Health Reform Workgroup recommendations around enrollment and education, in order to ensure efficient adoption of Medicaid expansion.[10]

Benefits of Increasing Insurance Options

The most obvious benefit to expanding Medicaid is increased access to health insurance and thereby health care for North Carolinians. Residents in all 100 counties will benefit from this new opportunity. (see Appendix). Up to 60,000 residents of our largest county (Mecklenburg) and up to 300 residents of our smallest county (Tyrrell) may benefit. It is important to note that these estimates are from census data and include all residents without respect to citizenship status. Further, some of these residents, especially those with incomes between 100 and 138% of the FPL may remain insured through the health care marketplace with premium support.

Health insurance confers numerous health and non-health benefits to participants. People who are uninsured are more likely to delay care and less likely to receive preventive services, primary care, or chronic care management. As a result, they are more likely to end up in the hospital with preventable health problems and more likely to die prematurely. When the uninsured do seek care, some of the costs of their care are shifted to the insured population.[11]

In addition, taking advantage of this mostly federally funded opportunity to expand insurance coverage to many North Carolina citizens has significant benefits to local communities and the state as a whole. Those benefits include health system benefits and economic benefits. First, as part of the ACA, Disproportionate Share Hospital (DSH) payments, which provide payment to hospitals based on the amount of care they provide to individuals without health care coverage, are scheduled to sunset in 2018. Non-expansion states have already seen more financial distress, especially among rural hospitals.[12] When DSH payments sunset, this will have a disproportionate impact on non-expansion states, making them even more vulnerable. North Carolina hospitals currently receive $321 million in DSH payments.[13] The ACA was designed to dramatically decrease the rates of uninsured consumers, thereby supporting health systems and health centers with claims for services. In states that have not expanded Medicaid, this potential has only been half met.

Economic benefits to communities and states have been dramatic in states that have chosen to participate in Medicaid expansion. One recent study of Medicaid expansion reported that North Carolina will lose an estimated $21 billion in federal funding between 2016

and 2020. This additional funding would result in 43,000 additional jobs and over $1 billion in state and county tax revenue. These employment and tax benefits accrue across all counties, rural and urban.[14]

This begs the question—in the context of federal health care reform discussions, what will happen if the ACA is repealed or substantially modified. In the current health policy environment, it is hard to predict if or how the ACA may change. However, one thing is clear, major changes in Medicaid will move toward more risk and more responsibility for administration of the program to states. This is consistent with both our current 1115 waiver and the Carolina Cares Act. Further, full repeal of the ACA would revert this FMAP for this option to the NC FMAP (currently 68%). In the recent repeal and replace bill, states that had chosen to expand Medicaid benefitted substantially in initial per capita allotments compared to non-expansion states.[15,16]

Path Forward for Medicaid Expansion in North Carolina

As the options for Medicaid expansion develop, policymakers, health care providers, and health system stakeholders will keep a close eye on the ways that each plan will impact costs of expanded coverage, quality of care, and, ultimately, the health outcomes for North Carolinians. With movement on both sides of the aisle toward increasing coverage, reducing costs of care, and providing for health and well-being, for the first time since the passage of the ACA, there is an opportunity to partner across party lines, chambers, and branches of government to expand of Medicaid in North Carolina for the benefit of the health and well-being of North Carolinians.

The North Carolina Institute of Medicine (NCIOM) serves as a non-political source of health policy analysis and advice in North Carolina. The NCIOM is an independent, quasi-state agency that was chartered by the North Carolina General Assembly in 1983 to provide balanced, nonpartisan information on issues relevant to the health of North Carolina's population. To meet its mission, the NCIOM convenes task forces of knowledgeable and interested individuals to study these issues and develop workable solutions.

For more information, visit www.nciom.org. For more information on this publication or the NCIOM, contact Adam Zolotor, MD, DrPH, President and CEO of the North Carolina Institute of Medicine at 919.445-6150, email at adam_zolotor@nciom.org, or visit www.nciom.org.

CONTRIBUTORS:
Michelle Ries, MPH, Project Director
Berkeley Yorkery, MPP, Associate Director
Adam Zolotor, MD, DrPH, President and CEO

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APPENDIX: Medicaid Eligibility by County

These are the adults who would be potentially eligible for Medicaid if the state chose to expand Medicaid to adults with incomes up to 138%. Some of these adults will be ineligible for Medicaid if they are undocumented immigrants.

Adults age 18-64 Under 138% FPL, by County

County	Adults	County	Adults	County	Adults
North Carolina	630,654	Gaston	14,093	Perquimans	772
Alamance	11,146	Gates	715	Person	2,434
Alexander	2,548	Graham	782	Pitt	12,575
Alleghany	1,179	Granville	3,108	Polk	1,286
Anson	1,756	Greene	1,676	Randolph	10,278
Ashe	2,237	Guilford	33,168	Richmond	3,974
Avery	1,374	Halifax	3,689	Robeson	13,900
Beaufort	3,084	Harnett	8,292	Rockingham	5,997
Bertie	1,356	Haywood	3,409	Rowan	10,017
Bladen	2,907	Henderson	7,014	Rutherford	4,713
Brunswick	6,745	Hertford	1,631	Sampson	5,334
Buncombe	16,922	Hoke	3,879	Scotland	2,431
Burke	6,606	Hyde	424	Stanly	3,608
Cabarrus	10,500	Iredell	9,225	Stokes	2,495
Caldwell	5,659	Jackson	3,511	Surry	5,743
Camden	472	Johnston	11,415	Swain	1,069
Carteret	3,898	Jones	797	Transylvania	2,101
Caswell	1,497	Lee	4,560	Tyrrell	381
Catawba	10,244	Lenoir	4,674	Union	10,070
Chatham	3,736	Lincoln	5,273	Vance	3,606
Cherokee	1,912	McDowell	3,101	Wake	46,983
Chowan	892	Macon	2,637	Warren	1,573
Clay	776	Madison	1,379	Washington	902
Cleveland	6,230	Martin	1,748	Watauga	4,133
Columbus	4,213	Mecklenburg	60,354	Wayne	9,141
Craven	6,074	Mitchell	992	Wilkes	5,554
Cumberland	18,982	Montgomery	2,288	Wilson	6,784
Currituck	1,257	Moore	4,761	Yadkin	2,686
Dare	2,112	Nash	5,718	Yancey	1,069
Davidson	11,105	New Hanover	13,407		
Davie	2,182	Northampton	1,374		
Duplin	6,861	Onslow	9,184		
Durham	19,439	Orange	7,551		
Edgecombe	4,235	Pamlico	718		
Forsyth	21,869	Pasquotank	2,304		
Franklin	4,106	Pender	3,698		

Source: US Census. Small Area Health Insurance Estimates (North Carolina, 2010) http://www.census.gov/did/www/sahie/data/interactive/