NORTH CAROLINA INSTITUTE OF MEDICINE
2006 TASK FORCE ON COVERING THE UNINSURED
UPDATES TO RECOMMENDATIONS (2008)

There has been substantial progress in implementing the recommendations of the North Carolina Institute of Medicine Task Force on Covering the Uninsured. In total, 62% of the recommendations have been either fully or partially implemented. Many groups are continuing to work on these recommendations.

Total recommendations: 13
Fully implemented: 3 (23%)
Partially implemented: 6 (46%)
Not implemented: 4 (31%)

EXPANDING THE SAFETY NET

Recommendation 1.1: PRIORITY RECOMMENDATION
The North Carolina General Assembly should help support and expand the existing healthcare safety net to be able to meet more of the healthcare needs of the uninsured.
Partial Implementation

During the 2007 legislative session the North Carolina General Assembly (NCGA) appropriated $5 million in nonrecurring funds and $2 million in recurring funds to expand the health care safety net. An additional $2.9 million in nonrecurring funds were appropriated to sustain coordinated networks for the uninsured through HealthNet. During the 2008 legislative session, the General Assembly appropriated $2 million in recurring funds and $4 million in nonrecurring funds to support the health care safety net infrastructure (Community Health Center grants program), and an additional $2.8 M recurring and $950,000 non-recurring funds to sustain indigent care networks and support new collaborations through HealthNet. Additional funding is needed to ensure that more of the health care needs of the uninsured can be met through safety net organizations.

TRENDS IN HEALTH CARE COSTS

Recommendation 4.1: PRIORITY RECOMMENDATION

a) **Individuals have a responsibility to understand their health needs and risks, and to be better stewards of their own health. To promote healthy lifestyles:**
   i. **Individuals should be given the education, support, and resources needed to make informed healthy lifestyle choices, and should make use of these resources to make healthy choices.**
   ii. **Individuals with chronic diseases should be provided information and access to health services in order to manage their health conditions, consistent with best known evidence-based care.**

iii. **Individuals who engage in risky health behaviors (such as smoking, sedentary lifestyles, or abuse of drugs or alcohol) should be expected to pay differential premiums to cover some of the increased healthcare costs of their unhealthy lifestyle choices.**

b) **Providers, employers, insurers, schools, and government should work together to promote healthy lifestyle choices, and encourage people to participate in evidence-based wellness initiatives.**
   i. **Insurers should develop insurance products with financial incentives that reward healthy lifestyle behaviors and should cover wellness related services (such as smoking cessation) as a basic benefit.**
   ii. **Providers should: educate individual patients and, where appropriate, their family members, about the importance of lifestyle choices in maintaining optimal health; provide information and referrals to help patients engage in healthy behaviors; and provide patients with the information and skills needed to manage chronic disease conditions.**
   iii. **Employers should, to the extent possible, establish policies and environments that support positive behaviors (i.e. access to healthy food in vending machines and cafeterias, ensuring a tobacco-free environment, encouraging activity at work) and offer wellness programs to engage employees in health awareness and improvement programs in the workplace.**
   iv. **Schools should also establish healthful policies and environments, including: healthy food in cafeterias; opportunities for all youth to be active daily at school, tobacco-free policies; and educational opportunities to teach students the importance of healthy lifestyles to maintain optimal health.**
   v. **Public health should continue and expand community-wide health awareness, promotion, nutritional information, and disease prevention activities.**
   vi. **Communities and governments should help support healthy communities by providing environments conducive to healthy lifestyle choices (including, but not limited to, walkways, bicycle paths, safe parks, and green spaces).**

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

Partial Implementation

During the 2007 legislative session, the NC General Assembly made changes to the North Carolina State Health Plan including authorizing the plan to incorporate incentives for healthy lifestyles. To help promote healthy lifestyles and management of chronic diseases to help reduce health care costs, the General Assembly included $2 million in recurring funds for support to local health departments (which can be used for

prevention), $2.7 million for additional school health nurses, $1 million nonrecurring funds for Healthy North Carolinians, and $250,000 in nonrecurring funds for pediatric diabetes education and prevention.

Since 2005, tobacco prevention and control initiatives in North Carolina have included the passage of smoke-free legislation and the subsequent implementation of tobacco-free policies, an increase in the cigarette excise tax, the installation of a state tobacco use quitline, mass media campaigns, and improved comprehensive public and private health insurance coverage for cessation services and products.

- The number of tobacco-free policies in schools, government buildings, hospitals and worksites in North Carolina has increased. In 2005, 11% of North Carolina hospitals had tobacco-free campus wide policies; currently, 75% do. Similarly, tobacco-free schools have also increased, up to 75% from 40% in 2005.[1] Legislation (SB 1086) was passed mandating all local school systems be tobacco-free by August 2008. Additional legislation (HB 24) ensures all state government building are tobacco-free (enacted January 1, 2008) and allows for regulation of smoking on the campuses of the UNC Health Care System, the East Carolina University School of Medicine and Physicians Practice Plan, and the buildings and grounds of the 16 University of North Carolina institutions (SB 862).
- In 2005-2006, North Carolina increased its cigarette tax by 30 cents, bringing the state cigarette tax up to its current rate of 35 cents. Increasing the unit price for tobacco products will help reduce the number of people who start smoking and help those who smoke quit.
- QuitlineNC, the state's first tobacco use quitline, began operation in November 2005. The quitline is a free resource for North Carolinians who are ready to quit tobacco use. More than 5000 callers have used the quitline for cessation assistance.[2] Many health care providers and health insurers are utilizing the NC Quitline for treatment of nicotine addiction among patients. For example, in 2007, the North Carolina State Health Plan began a program to waive the $5 copay for over-the-counter (OTC) generic nicotine replacement patches for members who receive tobacco cessation support through QuitlineNC.
- Over the last few years, North Carolina has had statewide mass media tobacco prevention and control campaigns such as TRU, Call It Quits, and Become an Ex. These campaigns have targeted youth and young adults and have promoted the quitline.
- Tobacco cessation benefits, riders, and programs are offered by all private and public health insurers in the state.[3] In 2006, Medicaid began covering all cessation pharmacotherapy with no prior authorization needed. In early 2007, the State

[1] NC Prevention Partners. (2008) North Carolina Prevention Report Card 2008: A Progress Report on Prevention and Health in North Carolina 2005-2007. Chapel Hill, NC.
[2] Tobacco Prevention and Control Branch, Division of Public Health, NC Department of Health and Human Services.
[3] NC Prevention Partners. (2008) North Carolina Prevention Report Card 2008: A Progress Report on Prevention and Health in North Carolina 2005-2007. Chapel Hill, NC.

Health Plan provided generic, over-the-counter (OTC) nicotine replacement therapy patches at no cost for three months to members.

Progress in smoking rates have also been made in regards to smoking rates in North Carolina. Cigarette use by adults decreased from 2001 to 2006. In 2001, 25.7% of adults smoked compared to 22% in 2006.[4] Youth cigarette use has also declined since 2003. In 2003, 27.3% of high school youth and 9.3% of middle school youth were current cigarettes smokers versus 19% and 4.5% in 2007, respectively.[5]

Tobacco prevention and control efforts in North Carolina provide an ideal model for other health promotion/disease prevention efforts to follow, such as those for increasing physical activity, improving nutrition, and decreasing overweight and obesity. Overall, preventive benefits, riders, and programs being offered by public and private health insurers in North Carolina have increased. The vast majority of private health plans offer physical activity benefits, riders, or programs. All public health plans in the state offer nutrition benefits, riders, or programs.[6]

Worksite wellness has become of increasing importance as more and more North Carolina employers recognize the importance of health behavior in disease prevention and health promotion. Encouraging and providing supportive environments for practicing healthy behaviors is paramount. Many North Carolina employers are recognizing the health importance of worksite policies that prohibit tobacco use, encourage physical activity, and promote good nutrition. Health insurers recognize the value in worksite wellness and assist businesses in strategizing to maintain and improve employee health. For example, through its EHP (Employer Health Partnership) effort, Blue Cross and Blue Shield of North Carolina helps large businesses develop custom worksite wellness initiatives. Another example is from the NC State Health Plan (SHP). To support members in practicing healthy behaviors, in October of 2005, the SHP launched NC Health*Smart*, an innovative initiative that includes, among other efforts, a focus on worksite wellness programs. In 2007, state agency employees benefited from the introduction of a worksite wellness toolkit, and currently, the toolkit is being introduced to employees within the public school system.

At the statewide level, the four largest North Carolina health care foundations have provided support for the North Carolina Institute of Medicine Task Force on Prevention. The NC IOM is working in collaboration with the NC Division of Public Health on the Prevention Task Force. The charge of the Task Force is to develop a Prevention Action Plan for the state that will incorporate evidence-based strategies to accomplish many of the goals set forth in this recommendation. The Task Force is chaired by Leah Devlin, DDS, MPH, State Health Director and William Roper, MD, MPH, CEO of the University of North Carolina Health Care System and Dean of the University of North Carolina School of Medicine. The Task Force includes an additional 46 members, including top

[4] Behavior Risk Factor Surveillance System, 2001, 2006
[5] NC Youth Tobacco Survey, 2008.
[6] NC Prevention Partners. (2008) North Carolina Prevention Report Card 2008: A Progress Report on Prevention and Health in North Carolina 2005-2007. Chapel Hill, NC.

leaders in the health care policy (legislative and executive agencies), and leaders from business, health care, public health, insurance, and faith-based sectors. The Task Force will meet on a monthly basis and will focus on tobacco use, nutrition, physical activity, risky sexual behavior, alcohol and substance use, emotional and psychological factors, exposure to environmental pollutants, bacteria and infectious agents, and injury. The work of the Task Force will culminate in a summit in the fall of 2009 to discuss strategies to implement the Prevention Action Plan.

Recommendation 4.2:
The North Carolina General Assembly should create a study commission to identify other ways to reduce the growth in healthcare costs, in order to lead to lower overall costs for private and public healthcare plans.
Partially Implemented

In 2008, the NCGA asked the NCIOM to convene a new panel to study issues related to access to appropriate and affordable health care for all North Carolinians.

PRIVATE OPTIONS TO EXPAND HEALTH INSURANCE COVERAGE

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

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

family incomes equal to or less than 250% of the federal poverty guidelines, are not currently insured and have not been for the past 12 months, are not eligible for employer-sponsored group coverage, and are not eligible for Medicare.

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

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

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

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

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

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

<u>Not Implemented</u>

During the 2005 legislative session the NCGA considered, but did not pass, a bill to create a Healthy North Carolina program similar to that proposed in this recommendation. In 2006 the NCGA passed the Small Business Tax Credit which allows employers with 25 or fewer employees paying at least 50% of health insurance costs to

receive a $250 tax credit per employee. The tax credit is currently scheduled to sunset on January 1, 2009.

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

a) **The study shall consider whether changes to any element of North Carolina's current small group rating system, to the definition of small employers or to how rating requirements apply to small employers of different sizes could be expected to result in increased coverage among small employers. In evaluating these questions, the experiences of other states' small group rating systems should be considered.**
b) **The North Carolina Department of Insurance should empanel a group that includes representatives of small business, brokers, underwriters, and other experts who can review the data and determine whether changes are needed to existing small group reform laws.**
c) **Funding for this study would enable the Department to secure data and expertise from consultants that otherwise would not be available to the Agency.**

Full Implementation

The Department of Insurance (DOI) convened a Small Group Informal Discussion Group (Discussion Group) to assist in a review of the Small Employer Group Health Insurance Reform Act. The goal of this Discussion Group was to review the law and regulations to determine if changes could improve market conditions and give small employers greater access to affordable health care coverage. The Discussion Group included representatives of large and small carriers active in the small employer group health market in North Carolina, DOI staff, insurance agents, and others with an historical and active interest and experience with the Act. The Discussion Group began its work in January 2006 and completed its review in March 2006. The DOI commenced work on this recommendation while the Institute of Medicine Task Force was meeting and presented its recommendations to a legislative committee around the same time that the Task Force's report was issued. Because the work had already been done, NCGA funding was not pursued.

Since the passage of the Small Employer Group Health Insurance Reform Act over 16 years ago, a number of changes have occurred making it increasingly difficult for small employers to continue to provide health care coverage to their employees. The Discussion Group identified some updates and improvements to the regulations that could improve market conditions and affordability of small group health plans. The following recommendations were accepted by DOI and proposed to the NCGA during the 2006 legislative session:

- In order to provide self-employed individuals more choices in terms of benefit plans and prices, amend the guaranteed issue requirement for self-employed

individuals to allow each small group carrier the option of offering popular plans on a guaranteed-issue basis in lieu of the underutilized Basic and Standard Plans.

- Because using a county-wide geographic rating factor did not give recognition to utilization and referral patterns across county lines and cost differentials associated with different medical care systems, redefine the demographic factor for geographic location to a mean medical care system factor.
- In order to improve the community rate for all small groups in the long term through increased participation and retention of lower risk groups, allow the limited use of a new demographic factor – industry – to be used in developing the rates for individual employer groups, with a cap of +/- 10 percent.
- In order to improve the community rate for all small groups in the long term through the attraction of low medical risks groups with rates that can more accurately reflect a group's own medical risk, expand the risk bands from +/- 20 percent to +/- 25 percent.
- Because of the underutilization and diminishing need for a reinsurance pool, eliminate the North Carolina Small Employer Health Reinsurance Pool.

House Bill 1987 was signed into law on July 23, 2006 and included all of the above recommendations.

After passage of House Bill 1987, [7] all small employer carriers were to make an election, to be in effect for two years, relating to the plans the insurer wished to guarantee issue to self-employed individuals—the Basic and Standard health benefit plans, the carrier's two most popular small group health benefit plans, or two representative plans. In early 2008, DOI received elections from all active small employer carriers for the bi-annual election period beginning with January 1, 2008.

During 2008, DOI is collecting data from participating insurers which will include the impact of the rating methodology related changes. However, because a multitude of factors unrelated to rate regulation affect health insurance markets (e.g., the impact of rising medical costs upon premiums, increasing use of health spending accounts and associated high-deductible plans, and general economic downturns), it will not be possible to definitively measure or even specifically identify the impact of these new laws upon the small group health insurance market as compared to the impact of these other factors. Additionally, part of the impact is likely attributed to the fact that some individuals who would have lost coverage due to its high cost if the laws were not changed did not lose coverage.

[7] During the 2007 legislative session, the General Assembly adopted necessary technical corrections to House Bill 1987.

Recommendation 5.3:

a) **The North Carolina Institute of Medicine Covering the Uninsured Task Force supports the work of the North Carolina Health Insurance Innovations Commission, whose statutory mandate is to investigate the problems small employers face when trying to purchase health insurance coverage, and initiate regional demonstration projects to pilot innovative health plans.**
b) **The North Carolina General Assembly should appropriate funds to support the work of the Health Insurance Innovations Commission.**

Not Implemented

The NCGA has not appropriated funds to support the work of the Health Insurance Innovations Commission.

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

Full Implementation

Tiered benefit packages offering lower cost health insurance products are available in North Carolina.[8] However, it is unclear how aggressively they are marketed or how many people have enrolled in them.

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

Not Implemented

The NCGA has not provided the North Carolina Department of Insurance (DOI) with specific authority or guidelines to change the application of state-mandated benefits as described in the recommendation, nor has DOI sought such authority or guidelines. DOI is not aware of any specific situation in which the applicability of state-mandated benefits has been identified as the reason an insurer has not sought approval of a plan containing new or innovative approaches to health insurance benefit design. Additionally, the insurance industry has not sought or approached DOI about legislation that would accomplish what the Task Force recommended. Therefore, DOI believes that the issue of state-mandated benefits acting as a block to the approval of health insurance coverage with new and innovative benefit designs is not significant at this time. Based on this, DOI does not expect to seek the authority or guidance mentioned in recommendation 5.5.

[8] These types of benefit packages are subject to health insurance mandates up to policy limits.

PUBLIC OPTIONS

Recommendation 6.1:
The Division of Medical Assistance (DMA) should increase outreach and further simplify the Medicaid application and recertification process to encourage those who are currently eligible to apply and maintain their eligibility. DMA should consider, but not be limited to, the following:

a) **Increasing the number of outstationed eligibility workers**
b) **Streamlining the recertification process**

Partial Implementation

It is unclear if the number of outstationed eligibility workers has increased because any outstationed workers in addition to those mandated by DMA[9] are hired at the discretion of the county and determined by contracts they enter into with the various hospitals, clinics and other agencies.

The Division of Medical Assistance (DMA) has implemented a 10 page mail-in application for the aged, blind and disabled. There has been no action on extending the length of time for recertification. When this recommendation was developed, DMA was mailing out reenrollment forms for children enrolled in North Carolina Health Choice or Health Check when their enrollment was up for renewal. DMA is now working on a similar system for the aged, blind and disabled. Additionally, counties now have the option of completing mail-in or telephone reviews rather than requiring recipients come into the office.

Recommendation 6.2:
The North Carolina General Assembly should enact legislation to reduce administrative barriers and increase processing efficiency, including:

a) **Eliminating the asset (resource) test for low-income parents**
b) **Expanding the eligibility certification period from six months to 12 months**

Not Implemented

The NCGA has not considered legislation to eliminate the asset (resource) test or to expand the eligibility certification period.

Recommendation 6.3: **PRIORITY RECOMMENDATION**
The North Carolina General Assembly should expand Medicaid to cover more uninsured low-income people. First priority should be to cover parents and pregnant women with incomes below 200% FPG with a limited benefits package.

a) **The North Carolina General Assembly should direct the North Carolina Division of Medical Assistance to seek an 1115 waiver to develop a limited benefit package. As part of the 1115 waiver, the North Carolina General Assembly should:**

[9] Counties are mandated to have eligibility workers in disproportionate share hospitals and federally qualified health centers.

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

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

Partial Implementation

During the 2007 legislative session, the NCGA fully funded NC Health Choice and included new funds to expand children's health insurance (NC Kids' Care) to uninsured children in families with incomes between 200% and 300% of the federal poverty guidelines. This expansion was scheduled to go into effect July 1, 2008 but was delayed due to changes to the Centers for Medicare and Medicaid Services rules limiting states ability to expand state children's health insurance programs to children in families earning above 250% of the federal poverty guidelines. During the 2008 legislative session, the NCGA authorized the Department of Medical Assistance to create NC Kids' Care to cover uninsured children between 200-250% of the federal poverty guidelines. NC Kids' Care is scheduled to go into effect July 1, 2009 or upon reauthorization of the federal SCHIP program and approval of a state plan amendment. Additionally, during the 2008 legislative session the NCGA provided $9.4 million in recurring funding to expand the NC Health Choice program to support an additional 7,341 children.

In 2007, the legislature also extended Medicaid to youth ages 18-20 transitioning out of foster care.

Recommendation 6.4:
The North Carolina Division of Medical Assistance should pilot the use of an individual health risk assessment (HRA) and follow-up coaching and counseling with individual recipients in one or more of the Community Care of North Carolina networks to:

a) **Determine the health risks of the Medicaid population**
b) **Identify priorities for wellness initiatives**

c) **Assess the costs of implementing a HRA program statewide or with targeted eligibility groups**
d) **Assess the potential cost savings from targeted wellness initiatives**

Partial Implementation

Community Care of North Carolina (CCNC) networks have used health risk assessments since the program began in 1998. Typically, all new enrollees complete an assessment. Due to the success of using health risk assessments, CCNC has begun targeting assessments towards high-risk groups. In 2007, CCNC began using a chronic care assessment for aged, blind and disabled patients in 11 of 14 networks. These assessments are used to provide better assessment, follow up and case management. The chronic care assessment should be program wide in the next year or two.

CCNC uses data from the general and chronic care assessments to inform wellness initiatives (e.g., flu shots), prioritize case management activities, and look at overall population savings.

Recommendation 6.5: PRIORITY RECOMMENDATION
The North Carolina General Assembly should enact legislation to implement a high-risk pool.

a) **Eligibility for the high-risk pool should be limited to individuals who:**
    i. **Are ineligible for Medicaid, Medicare, or COBRA coverage, and**
    ii. **Are unable to purchase a policy except with a premium that is higher than that offered through the pool, or have been rejected by a commercial insurer due to pre-existing health problems.**
b) **Individuals who enroll in the high-risk pool shall be subject to a pre-existing condition exclusionary period of up to 12 months unless the individual had creditable prior coverage, in accordance with NCGS §58-68-20(c).**
    i. **The North Carolina General Assembly should create an open-enrollment period of six months when the program first becomes operational to allow individuals to enroll in the program with a reduced pre-existing condition exclusionary period of six months.**
c) **Premiums should be limited to 150% of the standard risk rate.**
    i. **The state should provide an additional subsidy to help individuals with incomes below 300% of the federal poverty guidelines pay for their share of the premium. The state subsidy would pay for 95% of the premium costs for individuals with incomes below 100% of the federal poverty guidelines to be phased out when a family's income reaches 300% of the federal poverty guidelines. The subsidy would be based on the lowest cost plan offered through the high-risk pool. Individuals who are eligible for a federal premium subsidy under the Trade Adjustment Act must apply for such coverage. The amount of the state subsidy will be reduced by any federal premium subsidy provided.**
    ii. **Nonsmokers or individuals who are actively participating in a smoking cessation program should be offered a discount off their premium.**

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

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

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

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

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

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

   i. **Premiums and other cost sharing for covered individuals**
   ii. **State appropriations to help pay the premium subsidy for individuals with incomes below 300% of the federal poverty guidelines**
   iii. **An assessment on covered lives on all health insurers, reinsurers, Multiple Employer Welfare Arrangements (MEWAs), Third Party Administrators (TPAs), Administrative Service Organizations (ASOs).**
   iv. **Provider reimbursement limited to the Medicare reimbursement rates**
   v. **North Carolina should seek federal grant funds, if available, to help support the implementation and ongoing costs of operating a high-risk pool.**

<u>Full Implementation</u>

During the 2007 legislative session, the NCGA enacted the North Carolina Health Insurance Risk Pool (NCHIRP)[10] which is scheduled to begin providing insurance January 1, 2009. Eligibility is limited to individuals who do not have access to group coverage as an employee or as a dependent of an employee, who do not qualify for any government program such as Medicare, Medicaid or SCHIP, and who meets any of the following:

- Has been rejected or refused by an insurer for similar coverage for medical reasons.
- Has been offered coverage by an insurer but with a conditional rider limiting coverage.
- Has been refused coverage except at a higher premium rate than the pool.
- Has similar coverage but at a rate higher than the pool.

[10]More information about Session Law 2007-532 is available online at: http://www.ncleg.net/Sessions/2007/Bills/House/HTML/H265v11.html. Information on the North Carolina Health Insurance Risk Pool from http://nchirp.org/aboutthepool.html.

- Has a diagnosed condition from a list of high-risk conditions to be determined by the pool's Board of Directors.
- Is a federally HIPAA eligible individual, including those who currently have this coverage through an insurer.
- Is a resident who is eligible for federal Health Coverage Tax Credit.

Eligible individuals who already have other non-group coverage in place will be eligible to move to the NCHIRP at any time, once it is open for enrollment.

The plans offered by NCHIRP will include a 12-month waiting period on coverage for pre-existing conditions. However, during the first 6 months that NCHIRP is open for enrollment, the waiting period will be just 6 months. Periods of prior coverage under another health plan will count towards satisfying these waiting periods in some cases; further details on this will be provided by NCHIRP.

NCHIRP's premium rates will be between 150% and 200% of the standard risk rate as determined by NCHIRP.[11] The premium rate for coverage will depend upon many items that are not yet defined or determined, and therefore is not predictable at this time. NCHIRP will provide at least two types of benefit plans to qualifying individuals, including preferred provider organization plans with differing levels of deductibles and cost-sharing, and at least one choice of a health savings account.

Special funds for start-up (i.e., development of NCHIRP's products and operations) will come from a one-time $250,000 appropriation by the State and a federal high-risk pool grant in the amount of $850,000. Funding for ongoing operations will come from premiums from enrolled individuals, a one-time $5 million grant from the North Carolina Health and Wellness Trust Fund, an annual transfer of state premium tax collections (a portion of revenue growth on existing taxes), and an annual payment from the North Carolina State Health Plan.

[11] "Standard risk rate" is essentially an average market rate for people who are covered under individual health insurance in the private market.