North Carolina Council on Health Care Coverage: Second Council Meeting

Hemi Tewarson

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December 18, 2020

Current state of health coverage

There are 1.2 million uninsured residents in North Carolina – a number that continues to grow.

Mission Statement

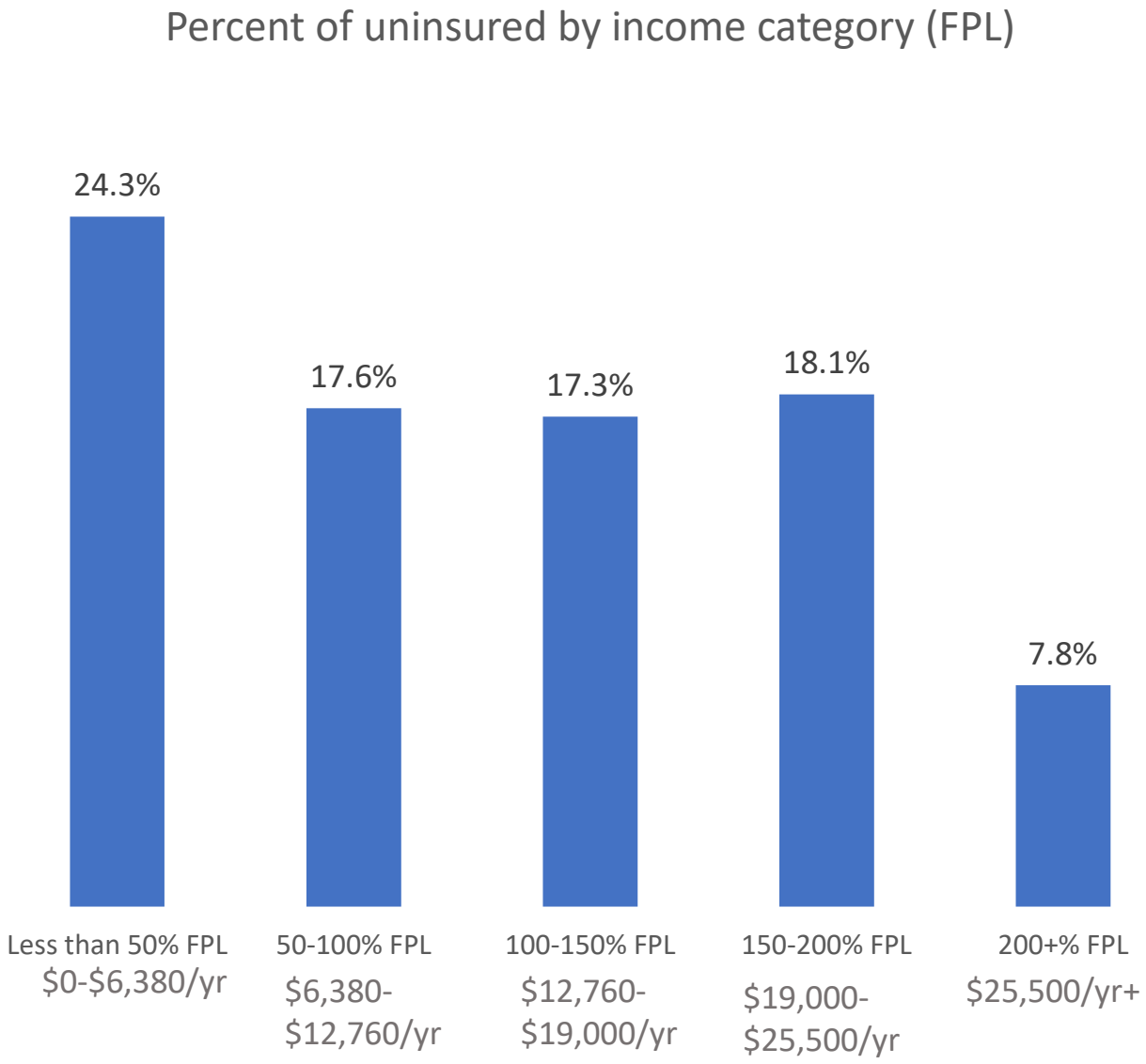
The Council is charged with reviewing the state of healthcare coverage in NC, exploring how other states have increased health care coverage, learning from other Council members, and developing a set of principles to guide policymakers in increasing coverage in the state.

Summary and Guiding Principles

- Council members will be asked to recommend guiding principles during the final meeting
- A brief report will be drafted to summarize the work of the Council and the guiding principles.
- The report will be shared with all Council members, posted on the Duke-Margolis Center website, and distributed to members of the NC General Assembly and other state leaders.

1.2 Million Uninsured in North Carolina

Lower income are more likely to be uninsured



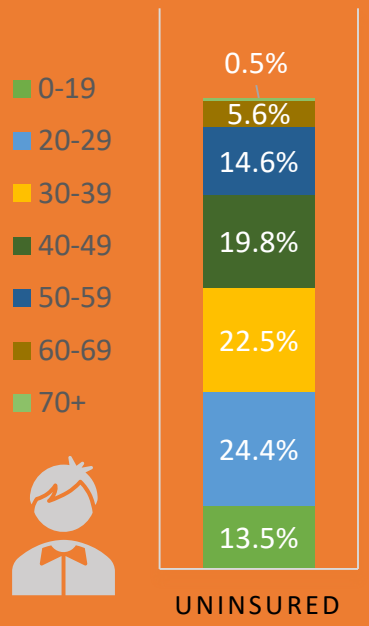
Sample Industries with Low-Income Uninsured Workers (Pre-Pandemic)

	Grocery Workers 19% Uninsured	Annual Income: $21,680 2018 Employer Insurance: 52%
	Nursing Home/Home Health 14%/19% Uninsured	Annual Income: $33,280/$29,952 (Direct care workers average $10/hour) 2018 Employer Insurance: 57%/39%
	Clothing Store Workers 14% Uninsured	Annual Income: $19,800 2018 Employer Insurance: 55%
	Hotel / Lodging Workers 28% Uninsured	Annual Income: $24,450 2018 Employer Insurance: 40%
	Restaurant Workers 28% Uninsured	Annual Income: $17,160 2018 Employer Insurance: 40%
	Hair Cutters 20% Uninsured	Annual Income: $28,320 2018 Employer Insurance: 37%
	Child Day Care Workers 20% Uninsured	Annual Income: $22,360 2018 Employer Insurance: 52%

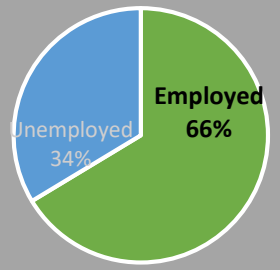
Who are the Uninsured in North Carolina?

Age

More than half of uninsured low-income adults are under 40



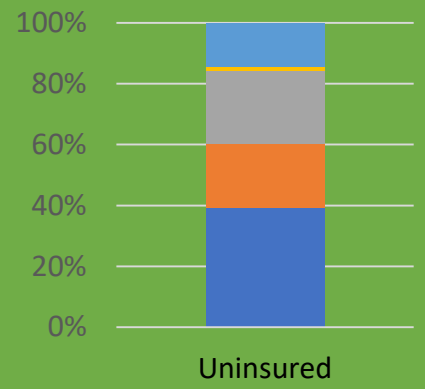
Employment Industries of Uninsured



Employment

Most uninsured are employed
High uninsurance rates in hospitality, retail, and manufacturing

Race / Ethnicity



Uninsured Adults In North Carolina Family Status

Family

Two in five uninsured adults are parents of children under 18.

Veterans

Tens of thousands of NC veterans are uninsured

30,000

Please include your 1 - 2 main priorities/ interest areas for increasing health care coverage in North Carolina.

Increased coverage and access for:

- Children, mothers, and pregnant women
- Parents of foster children
- Rural areas
- Substance use disorder and mental health services
- The uninsured and underinsured
- Veterans ineligible for VA benefits
- Essential workers

Reducing disparities in coverage

Closing the coverage gap

Medicaid expansion

State Innovation Waivers

Association Health Plans

Provider solvency/ stability (hospitals, primary care, behavioral health)

Support for safety net providers

Access to quality care

Telehealth access and coverage

Assistance/ tax credits for small businesses to provide coverage

State subsidies for purchasing exchange plan coverage

Please list other coverage options that you want to make sure the council learns more about.

Association health plans (and the associated outcomes and costs)	State reinsurance plans	Medicaid expansion
Expanding access to rural areas	Healthcare workforce	Scope of practice
Certificate of need modifications	Telehealth	Dental and vision coverage

Contact

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Focus on Key Medicaid Populations

Dave Richard
Deputy Secretary, NC Medicaid

December 18, 2020

Specific Medicaid Populations

Coverage for Pregnant Women

Parents of Children in Foster Care

HCBS Waiver Populations

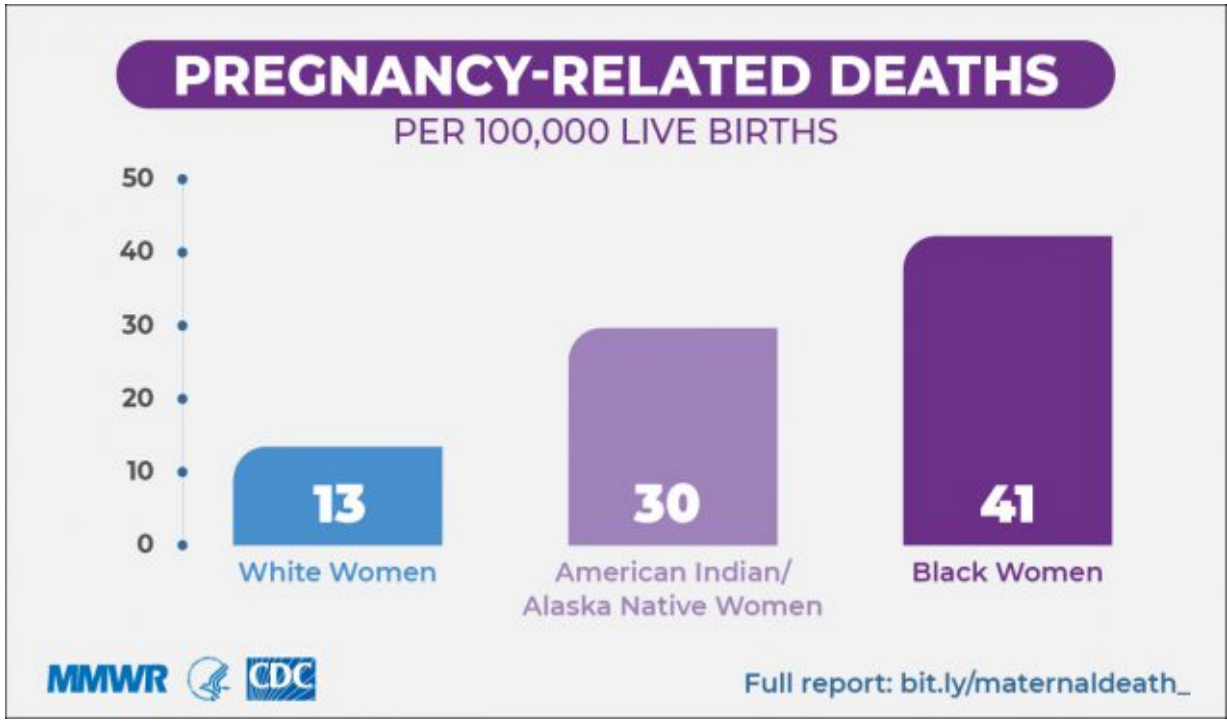
Maternal and Infant Morbidity and Mortality Crisis

United States:

- The US is the only industrialized nation to experience an increase in maternal mortality from 1995-2015.
- Black mothers are 3-4 times more likely to die in childbirth than White mothers.
- Maternal related deaths and illness can occur up to a year following birth.

North Carolina

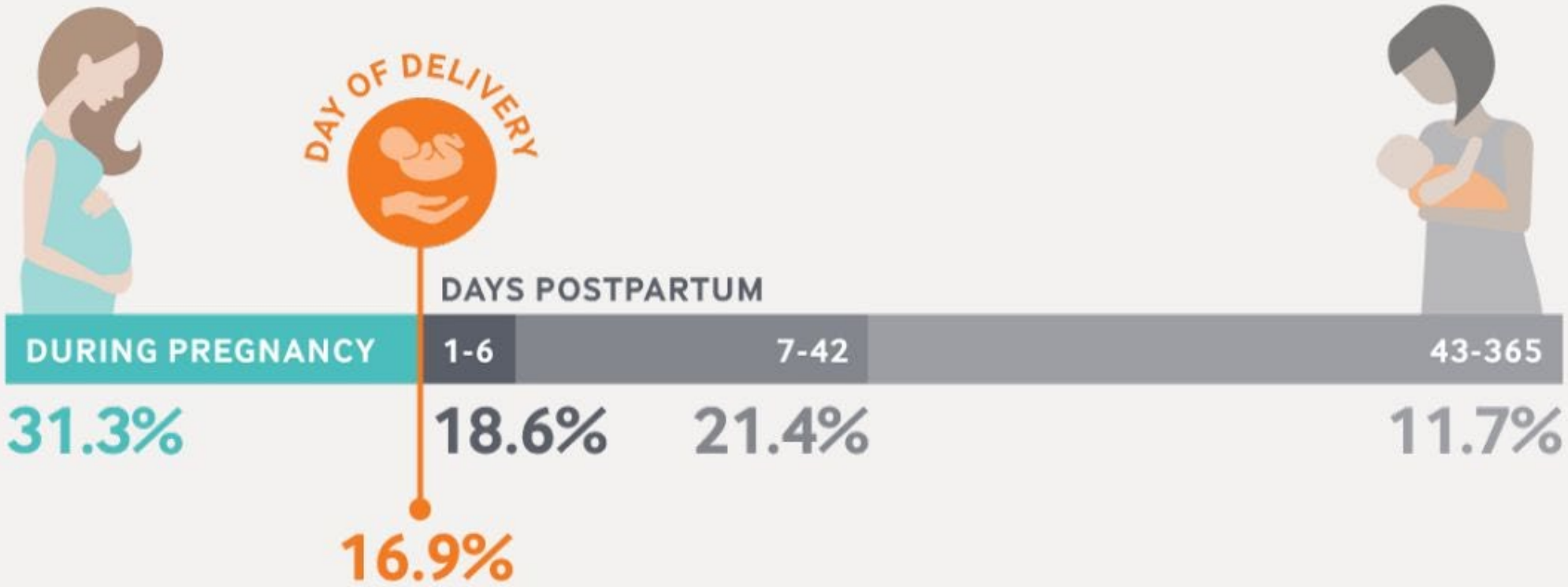
- NC ranks 30th in the country in terms of maternal mortality rates.
- 12% of women in NC experience postpartum depression.
- NC ranks 39th nationwide in infant mortality.
  - North Carolina earned a D+ on the March of Dimes' 2019 report card.



Maternal Health Risks Persist After Childbirth

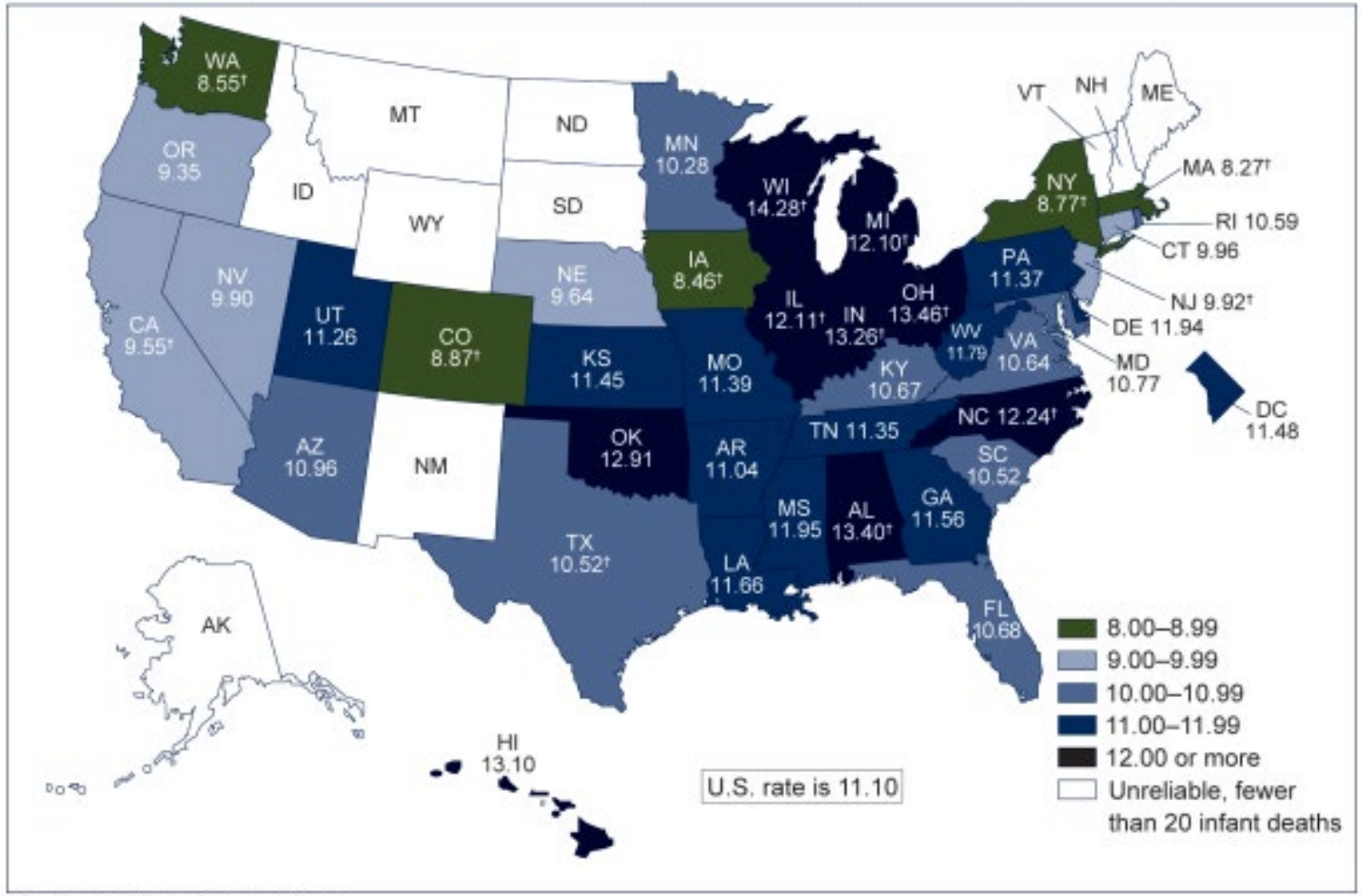
More than half of pregnancy-related deaths occur in the postpartum period, and 12 percent are after the standard six-week postpartum visit.

When deaths occur:[1]



Infant Mortality in the US

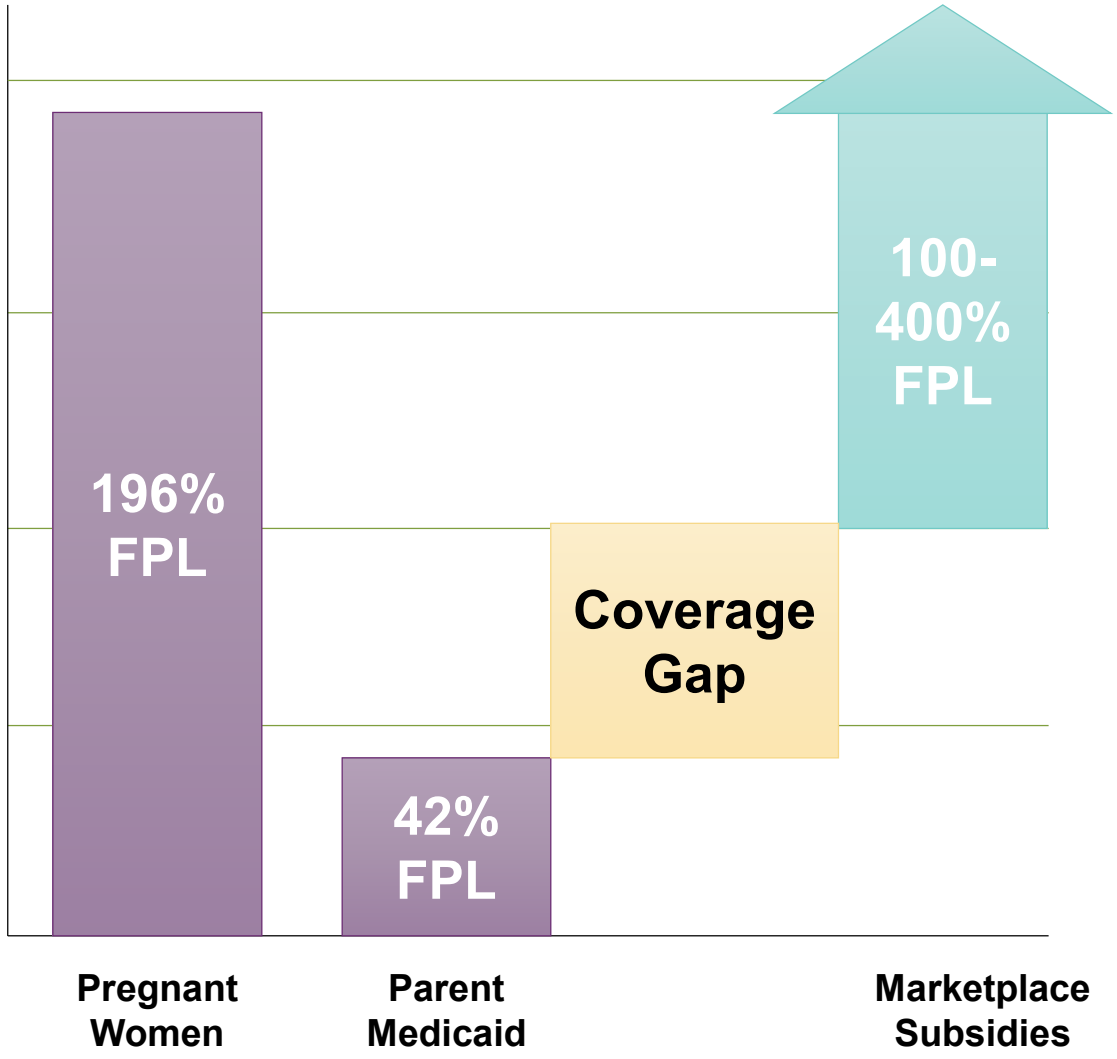
Figure 3. Infant mortality rates for infants of non-Hispanic black women, by state: United States, 2013–2015



† Significantly different from the U.S. rate.
NOTES: Rates ranged from 8.27 to 14.28 per 1,000 live births.
Access data table for Figure 3 at: https://www.cdc.gov/nchs/data/databriefs/db295_table.pdf.
SOURCE: NCHS, National Vital Statistics System.

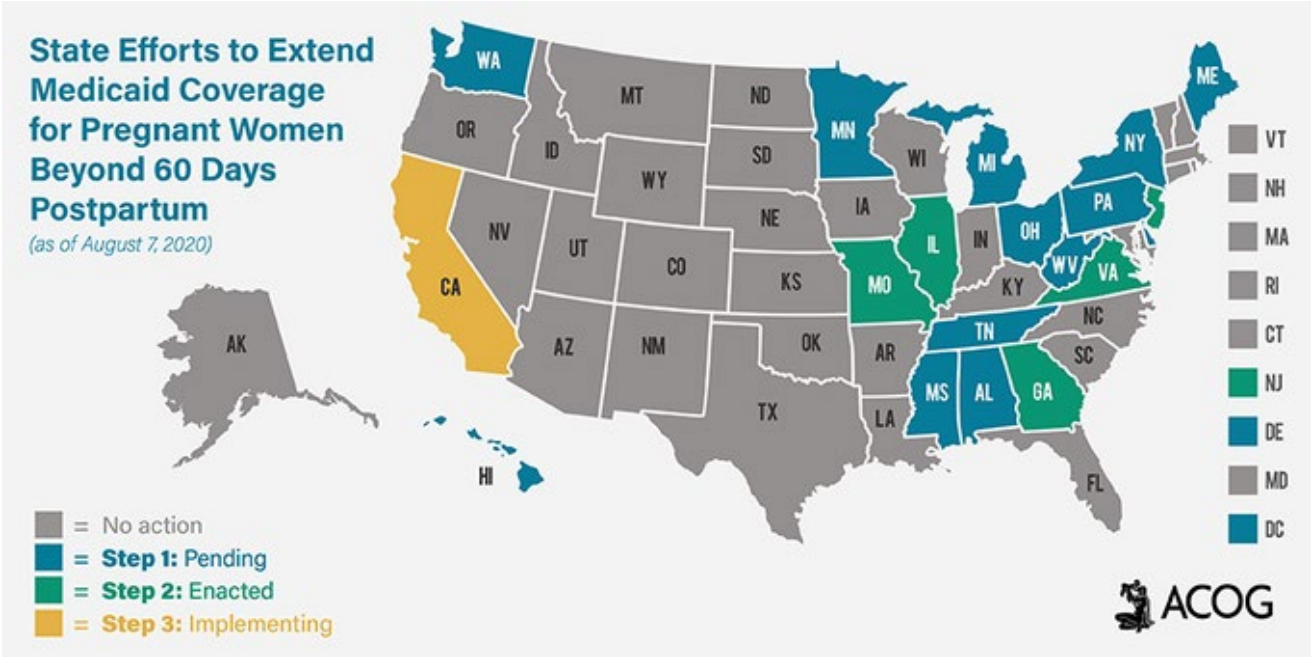
Medicaid and Pregnancy Coverage

- NC Medicaid pays for approximately 55% of all births in the state and covers pregnant women up to 196% of federal poverty (~$2,085/month).
- Women are eligible for NC Medicaid from prenatal care to up to 60 days after birth for services such as:
  - Childbirth classes
  - Health services that may complicate the pregnancy
  - Family planning services
- Coverage ends 60 days after birth for moms with incomes between 42% FPL and 196% FPL



Expanding Postpartum Coverage

- Federal Medicaid matching money is only available for 60 days after birth.
- Five states have passed legislation to extend postpartum coverage.
- Three states (Illinois, New Jersey, and Missouri) have applied for an 1115 waiver to extend postpartum coverage to one year.
  - CMS has not approved these waivers.
- California and Texas use state-only funds to provide coverage to a subset of women.



Parents of Foster Children

- Medicaid eligibility ends for parents if their children are moved to foster care.
- Approximately 40% of children entering foster care due to parent substance use.
- When parents lose eligibility, they may lose access to opioid treatment or other health care that could assist reunification.
- Approximately 6,000 children enter foster care annually, many of whose parents are eligible for Medicaid at current parent eligibility levels (41% FPL).

North Carolina's HCBS Waivers

Innovations

Provides services for people with intellectual or developmental disabilities (I/DD) to stay in the home or community instead of an institutional setting.

Current enrollment cap: 13,138 people

TBI

Provides services to those with traumatic brain injury to receive services in the home and community.

Current enrollment cap: 107

Community Alternatives Program (CAP) for children and disabled adults

Provides services for children ages 0-20 and disabled adults respectively, who need higher level of personal and home and community-based care serving approximately 15,000 beneficiaries.

CAP-C enrollment cap: 4,000 people

CAP-DC enrollment cap: 11,214 plus 320 Alzheimer's reserved slots

Waiver Waitlists

- Waiting lists are a function of the enrollment caps that are defined by the state and the populations of potentially eligible people in the state.
- States can increase the number of people covered by an HCBS waiver (the enrollment cap) and doing so would increase the cost of the program.
- Medicaid expansion does not introduce limitations on a state's ability to expand HCBS waiver slots.

Current Waitlists for NC Waivers

Innovations
Current waitlist is approximately 14,000 people

TBI
Currently no waitlist

Community Alternatives Program (CAP) for children and disabled adults
Current waitlist for disabled adults is 1788 people
Currently no waitlist for CAP for children

Expanding Health Care Coverage in North Carolina

NC Council on Health Coverage

Jordan Roberts

John Locke Foundation

12/18/20

What is the problem?

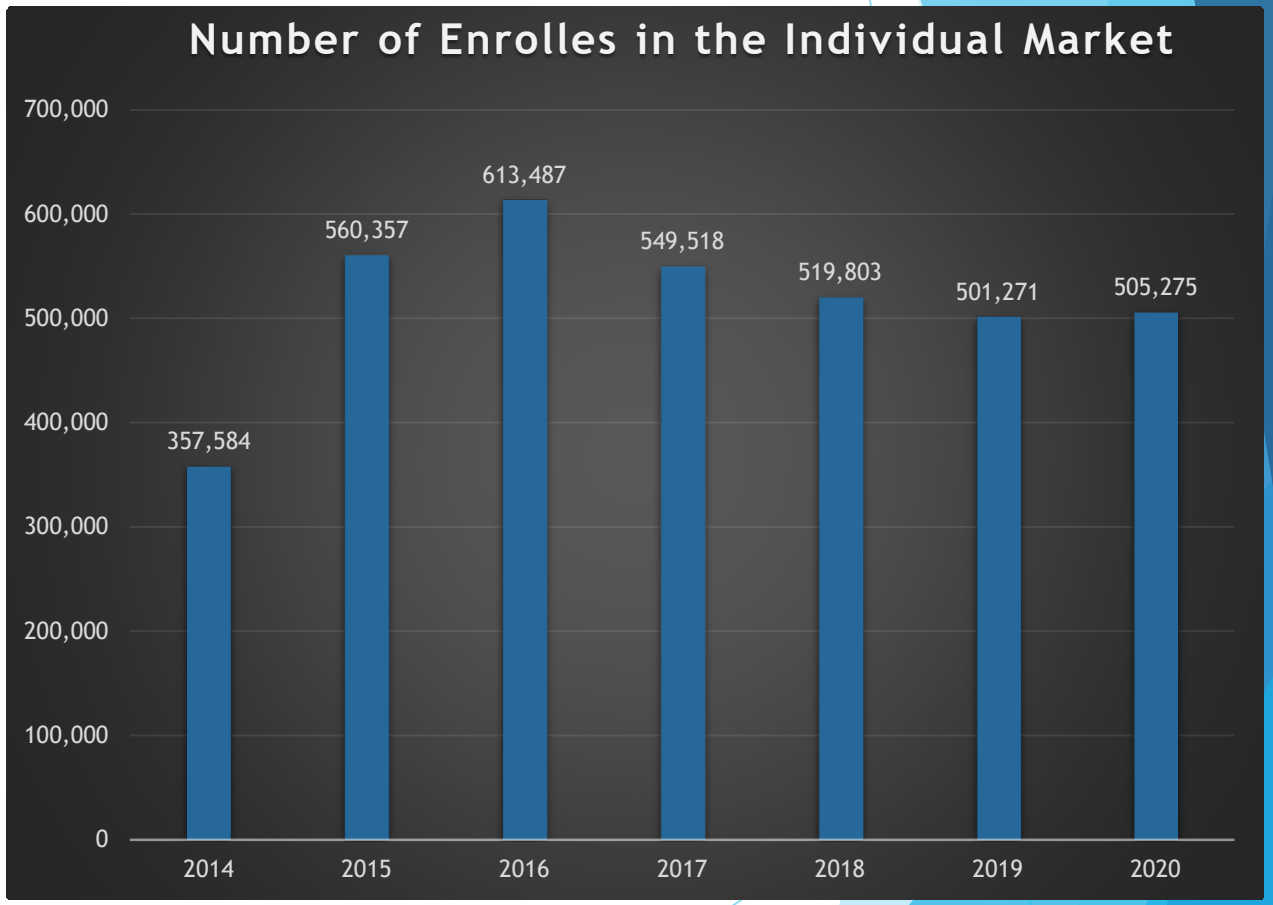
Health Care Cost Problems

- What is the problem we want to solve?
  - Health insurance can be unaffordable for those who don't get insurance from work or are on a public program
  - Those who do have health insurance may struggle to pay premiums
- What causes this problem?
  - The cost of health care drive the cost of insurance
  - Part of the coverage discussion needs to focus on reforms that loosen health care regulations and bring down the cost of care

Where are the opportunities for reform?

North Carolina's Individual Market

- What is the individual market?
  - For those who don't get health insurance from work or the government
- What is the status of North Carolina's Individual Market?
  - Participation in the exchange has declined over the past several years until 2020
  - 338,200 uninsured North Carolinians were eligible for a free ACA plan in 2020
  - Participation has declined despite the individual mandate being enforced up until 2019
  - This is mainly due to rising premiums and deductibles
  - Vast majority of NC counties only have one insurer offering coverage on the exchange



Source: Kaiser Family Foundation

What are the solutions?

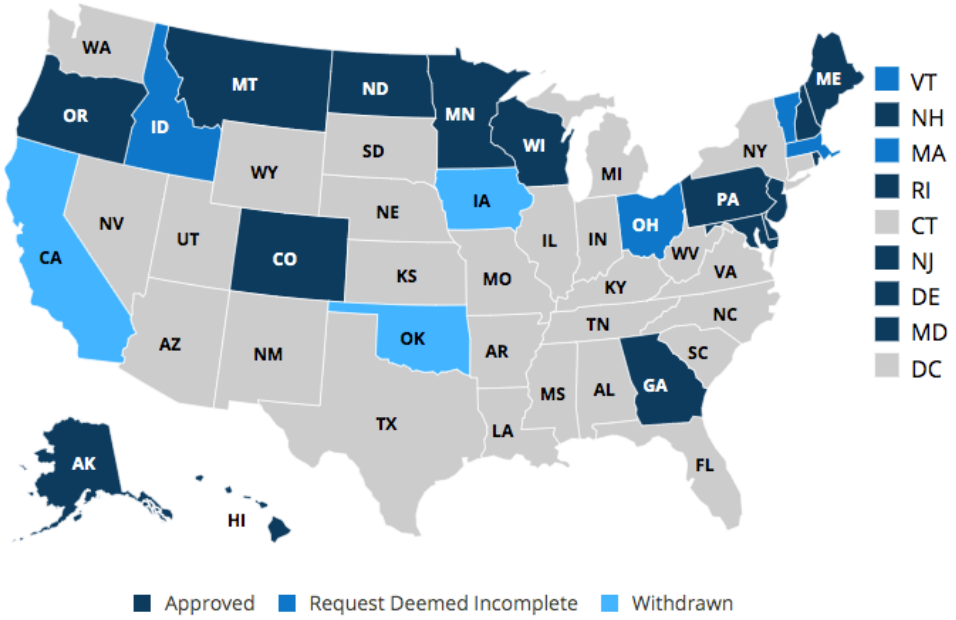
Solution #1: State Empowerment and Relief Waivers

- Under section 1332 of the ACA, states can waive regulations imposed on the individual market
- Gives states the opportunity to exert more control over the health insurance plans offered to its residents
- Most states have set up reinsurance programs, but this is not the only reform allowed by section 1332 waivers
- 4 “guardrails” a state must comply with for a 1332 waiver:
  - Comprehensiveness
  - Affordability
  - Coverage
  - Will not increase the federal deficit

Table 1: Estimated Individual Market Impact of State Reinsurance Programs in Year of Enactment

State (Date of Enactment)	Percent Change in Average Individual Market Premiums	Federal Pass-Through Funding (millions)	State Reinsurance Funding (millions)	Percent of Program Cost Born by State	Enrollment in Year of Enactment
AK (2017)	-34.7%	$58.5M	$1.5M	2.5%	14,200
MN (2018)	-20%	$131M	$140M	51.7%	106,500
OR (2018)	-6%	$54.5M	$35.5M	39.4%	143,200
ME (2019)	-9.4%	$65.3M	$27.7M	29.8%	62,100
MD (2019)	-43.4%	$373.4M	$88.6M	19.2%	181,500
NJ (2019)	-15.1%	$180.2M	$143.5M	44.3%	331,000
WI (2019)	-10.6%	$127.7M	$72.3M	36.1%	203,000
State Average	-19.9%	$141.5M	$72.7M	31.9%	148,800
Total	--	$990.6M	$509.1M	--	--

Source: Avalere



Source: Kaiser Family Foundation

Reinsurance programs in Other States

- Reinsurance works as stop-loss insurance for insurers participating in the market
- Both red and blue states have had 1332 waivers granted
- Premiums have been reduced by large margins in states that have set up reinsurance programs
- The state receives the difference between what the federal government spent before and after the waiver
- Reinsurance can bring more insurers onto the exchange
- Can also bring more covered lives into the risk pool

Georgia's State Innovation Waiver

- Two-part waiver
  - State reinsurance program
    - The reinsurance program will reimburse claims at an average coinsurance rate of 27% on claims between $20,000 and $500,000
    - Funded through a combination of general fund money, user fees, federal pass-through money
  - Georgia Access Model
    - Transition from a Federally-facilitated exchange to a model where private entities such as carriers, web brokers, agents will provide means to sign up for health insurance
    - High emphasis on local entities working with communities to sign up for health insurance through the program

Source: CMS

Solution #2: Association Health Plans

- AHPs are a type of large group health plan offered by business and trade associations to its member employers
- These plans allow small businesses and self-employed owners to band together to purchase health insurance as a large group
- ACA segments the market with a different set of regulations for small group and individual plans compared to large group plans
- AHPs are subject to the same rules as current large group health plans
- One of the first AHP's set up by Land O'Lakes Co-Op offered member plans with robust benefits that cost 20-30% less than comparable ACA plans
- Sole proprietors and small businesses would benefit the most

Source: https://www.johnlocke.org/policy-position/association-health-plans/

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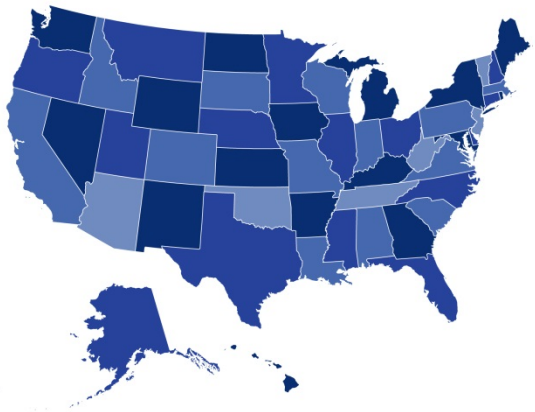
The North Carolina Council for Health Care Coverage Meeting #2

December 18, 2020

Sabrina Corlette, J.D.



About Georgetown's Center on Health Insurance Reforms (CHIR)

- A team of experts on private health insurance and health reform
- Conduct research and policy analysis, provide technical assistance to federal and state officials and consumer advocates
- Technical assistance providers to the Robert Wood Johnson Foundation's State Health & Value Strategies project*
- Learn more at https://chir.georgetown.edu/
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**The views expressed here do not necessarily reflect the views of the Robert Wood Johnson Foundation.*

Supporting the Pool: Reinsurance

- Reinsurance (RI) partially compensates insurers with individual market enrollees with very high health costs.
- ACA's federal RI program expired in 2016, contributing to an increase in individual market premiums for people above 400% FPL.
- States can implement their own RI programs and have it partially financed by the federal government through a 1332 waiver.
- By 2021, 14 states will be operating RI programs in the individual market.

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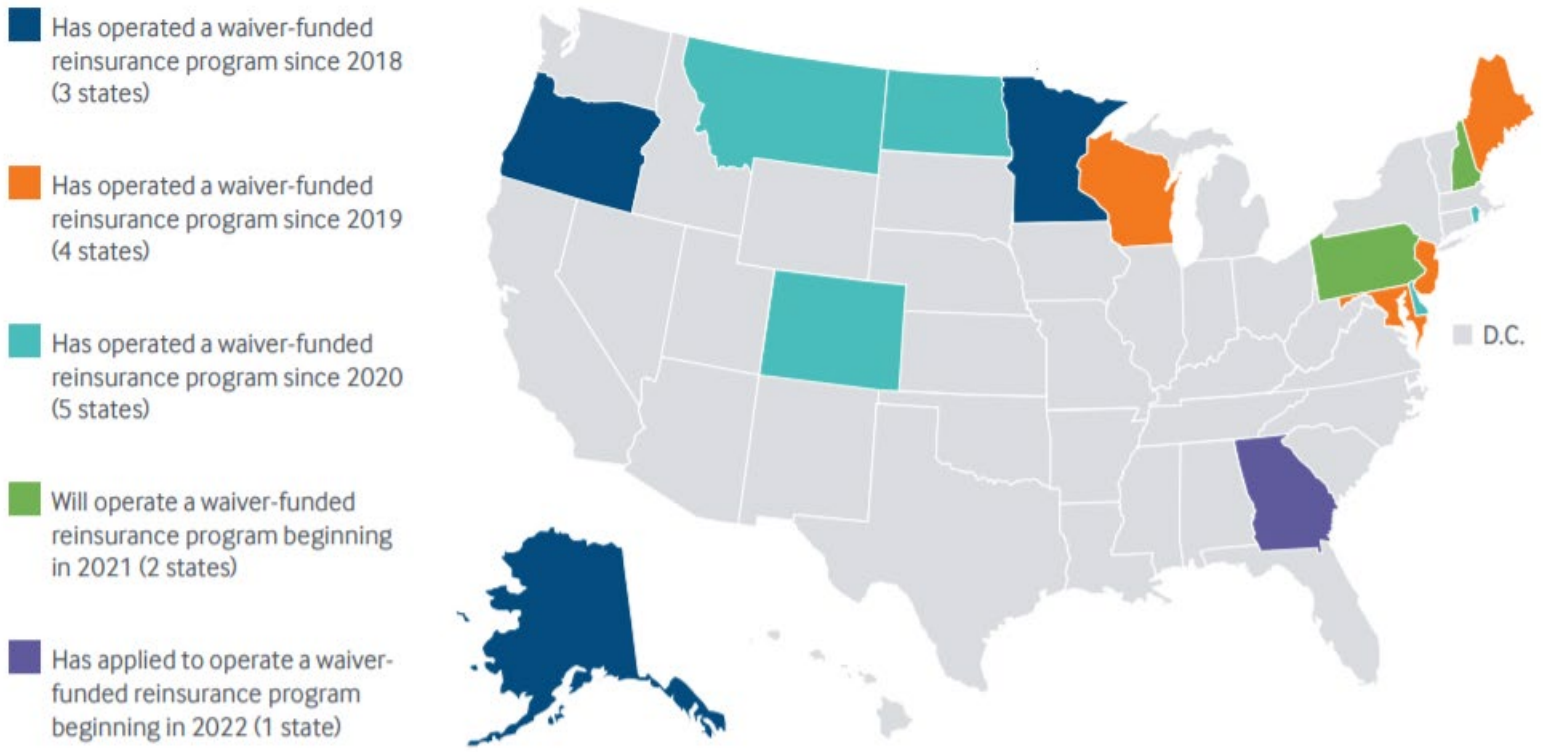
State Implementation

Exhibit 1. State Individual Market Reinsurance Programs Supported by Section 1332 Waiver Funding, by Year of Adoption



Notes: Section 1332 of the ACA authorizes states to apply to waive specified provisions of the health law to facilitate state-specific programs for improving coverage. If a state's "innovation waiver" program is forecast to reduce federal spending, the state is entitled to have these savings passed through to it for purposes of implementing the program. The states identified in this map have secured, or are seeking, approval for innovation waivers that use these federal "pass-through" funds to partially finance the state's reinsurance program.

Data: Authors' analysis.

Impact on Unsubsidized Premiums

Exhibit 2. Impact of Waiver-Funded State Reinsurance Programs on Individual Market Unsubsidized Premiums, 2018–2020

	Average percentage-point reduction in unsubsidized premium rates because of reinsurance		
State	**2018**	**2019**	**2020**
Alaska	30.2%	34.0%	37.1%
Colorado	—	—	22.4%
Delaware	—	—	13.8%
Maine	—	13.9%	7.2%
Maryland	—	39.6%	35.8%
Minnesota	16.8%	20.2%	21.3%
Montana	—	—	8.9%
New Jersey	—	15.5%	16.9%
North Dakota	—	—	20.0%
Oregon	7.2%	6.7%	8.0%
Rhode Island	—	—	3.8%
Wisconsin	—	9.9%	11.0%

Note: The table displays the difference in the average statewide premium with waiver-funded reinsurance and without it, where each rating area within the state is weighted equally.

Data: Center for Consumer Information and Insurance Oversight, State Relief and Empowerment Waivers: State-Based Reinsurance Programs, June 2020.

Post-Reinsurance Enrollment

Exhibit 3. Total Number of Consumers Who Selected a Marketplace Plan by the End of Open Enrollment, 2017–2020

State	2017	2018	2019	2020	Change in plan selections, pre/post program implementation*
Reinsurance programs implemented in 2018					
Alaska	19,145	18,313	17,805	17,696	–7.6%
Minnesota	109,974	116,358	113,552	110,042	0.1%
Oregon	155,430	156,105	148,180	145,264	–6.5%
Total U.S.	***12,216,003***	***11,750,175***	***11,444,141***	***11,409,447***	***–6.6%***
Reinsurance programs implemented in 2019					
Maine	79,407	75,809	70,987	62,031	–18.2%**
Maryland	157,832	153,584	156,963	158,934	3.5%
New Jersey	295,067	274,782	255,246	246,426	–10.3%
Wisconsin	242,863	225,435	205,118	195,498	–13.3%
Total U.S.	***12,216,003***	***11,750,175***	***11,444,141***	***11,409,447***	***–2.9%***
Reinsurance programs implemented in 2020					
Colorado	161,568	161,764	170,325	166,852	–2.0%
Delaware	27,584	24,500	22,562	23,962	6.2%
Montana	52,473	47,699	45,374	43,822	–3.4%
North Dakota	21,982	22,486	21,820	21,666	–0.7%
Rhode Island	29,456	33,021	34,533	34,634	0.3%
Total U.S.	***12,216,003***	***11,750,175***	***11,444,141***	***11,409,447***	***–0.3%***

Note: The table displays total plan selections at the end of each open enrollment period, not effectuated enrollments.

State-level Reinsurance

Pros

- Lowers unsubsidized individual market premiums
- Leverages federal pass-through dollars via 1332 waiver

Cons

- State must finance a portion of reinsurance fund
- Little impact on enrollment, could actually increase net premiums for some under 400% FPL

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Shifting the Deck Chairs: AHPs

- A longstanding option for individuals/employers
- Often offered to meet health insurance needs of trade/business association members
- Jointly regulated by states and federal government
- Pre-ACA
  - Often exempted from state insurance rules
  - Often raised concerns over insolvency, even fraud
- Post-ACA
  - 2011: Federal regulation: AHPs must follow same rules as ACA plans (called the “look through” rule)
  - 2018: Federal regulation: AHPs may qualify for exemptions from the market rules that apply to ACA plans (vacated by federal court, appeal pending)

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AHPs/MEWAs: State Action

- Nearly half of the states responded to the 2018 AHP rule
- Goal 1: Limit risk of insolvency, fraud by:
  - Prohibiting certain AHPs
  - Setting additional standards
  - Strengthening licensing requirements
- Goal 2: Maintaining a level playing field, limiting adverse selection, by
  - Maintaining 2011 “look through” rules
  - Prohibiting enrollment of self-employed
- Goal 3: Expand availability of lower-cost insurance options by conforming to the 2018 federal rules (on hold due to litigation)

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AHPs/MEWAs

Pros

- Lower premiums for healthier employers, individuals

Cons

- Higher premiums for older, sicker small employers, individuals
- Long history of insolvency, fraud

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Resources

- **Reinsurance**
  - Giovannelli J, Volk J, Schwab R, Curran E. "The Benefits and Limitations of State-run Individual Market Reinsurance," *Commonwealth Fund*, November 2020.
  - Tolbert J, Diaz M, Hall C, Mengistu S. "State Actions to Improve the Affordability of Health Insurance in the Individual Market," *KFF*, July 2019.
- **AHPs/MEWAs**
  - Corlette S, Hammerquist J, Nakahata P. "New Rules to Expand Association Health Plans," *The Actuary*, May 2018.
  - Lucia K, Giovannelli J, Corlette S, Goe C. "In the Wake of New Association Health Plan Standards, States Are Exercising Authority to Protect Consumers, Providers, and Markets," *Commonwealth Fund*, November 2018.

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Questions?

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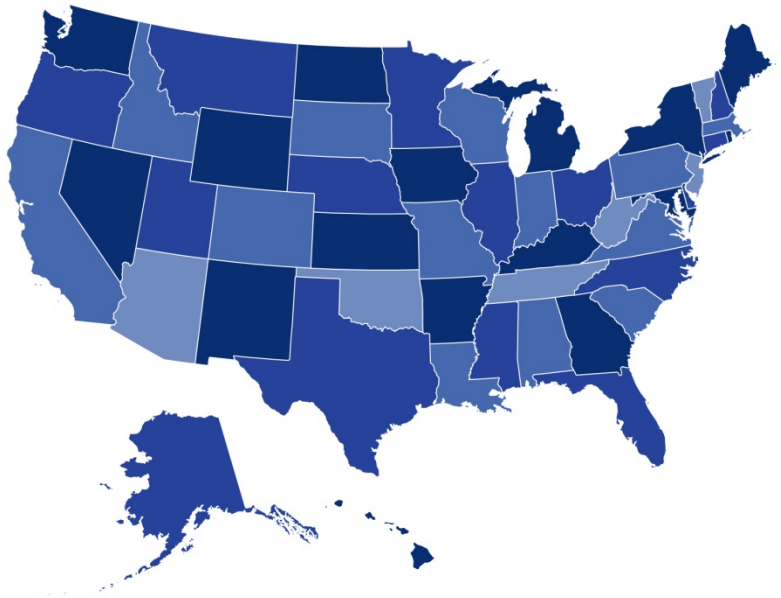

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NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Identifying and Addressing Behavioral Health Needs in North Carolina

Kody H. Kinsley
Operations Lead, COVID-19 Response
Deputy Secretary for Behavioral Health & IDD

December 18, 2020

Behavioral Health & IDD By the Numbers

Public System	Received Behavioral Health &/or IDD Services FY 2020
1.8 million people have Medicaid	280,000 Medicaid beneficiaries
1.2 million people are uninsured	106,000 uninsured

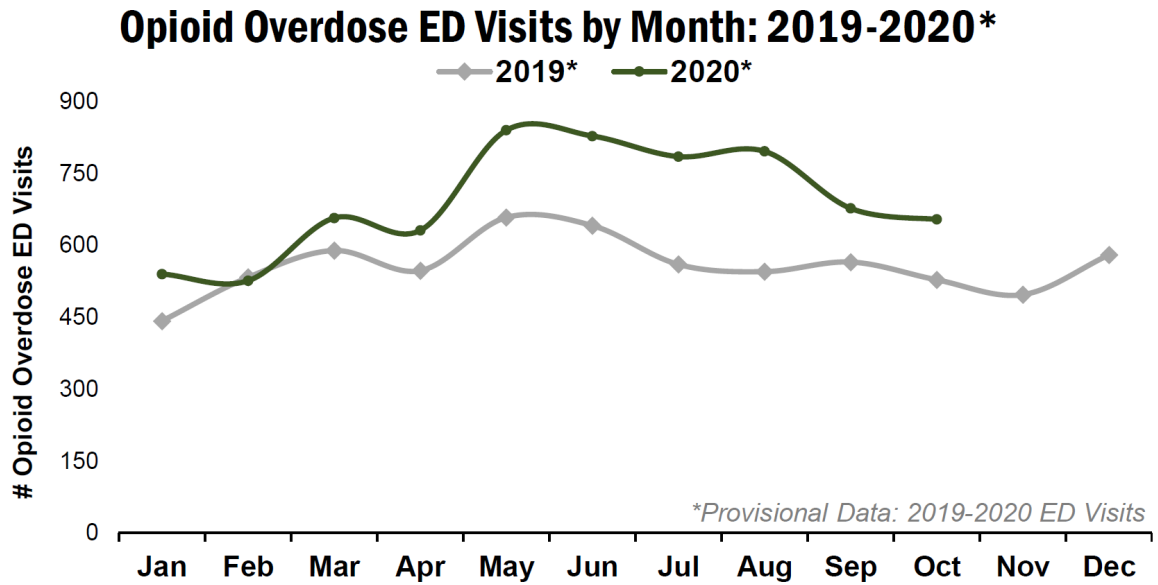
10.6 million residents, 1.8 million Medicaid, 1.2 million uninsured, 7.6 million Private/Military/Medicare insurance

State-Funded Services (State Fiscal Year 19-20)

Type of Service Need	Dollar amount	# of People Served	Top Services (based on dollars)
Mental Health	**$132,646,000**	**68,094**	• Inpatient Hospital • Outpatient Services • Residential Supports • Assertive Community Treatment Program
Substance Use Disorder	**$109,554,624**	**39,768**	• Facility Based Crisis Services • Opioid Treatment Program • Residential Supports • Substance Abuse Intensive Outpatient Program
Developmental Disability	**$59,147,870**	**5,253**	• Residential Supports • Adult Developmental Vocational Program (ADVP) • Personal Assistance • Day Activity

Approximately $175 million in expenditures for Non-UCR funding and it funds services and supports like substance use prevention services, TBI services, NC START, and community-based crisis services.

Indicators of System Performance



While NC experienced a 19% decrease in overall Emergency Department visits through August, we saw a 24% increase in opioid overdose ED visits.

Though, opioid overdoses declined through September and October following interventions.

- During the pandemic, there has been **a three-fold increase in reported symptoms of depression and/or anxiety disorders** – 1 in 3, up from 1 in 9 in 2019.
- On average for State Psychiatric Hospitals, **admission delays** for people who are referred from Emergency Departments have **increased from an average of 145 hours** in FY20 **to an average of 185 hours** in the First Quarter of FY21..
- In the last decade, there's been a **91% increase** in the use of **involuntary commitment (IVC)** in North Carolina.

APPENDICES

Prevalence of Behavioral Health Needs

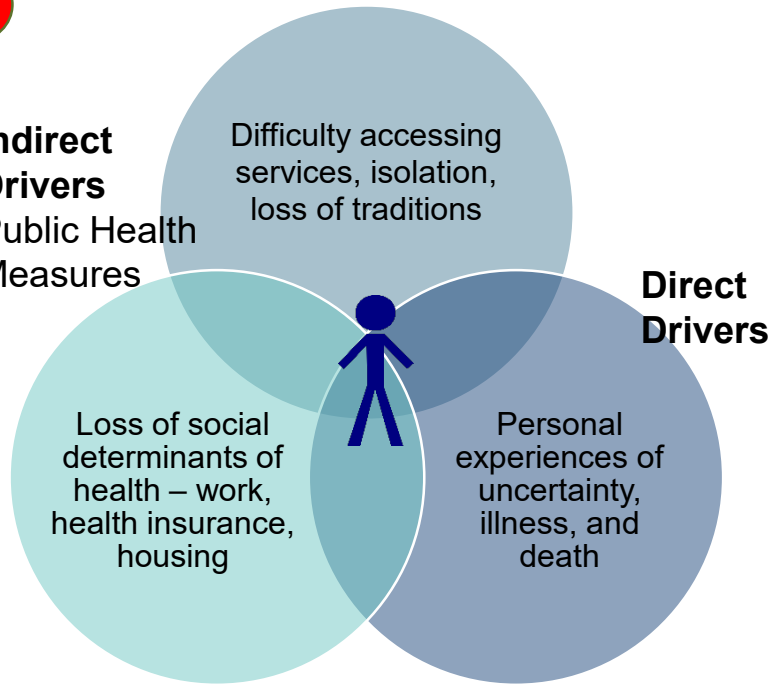
Pre-Pandemic – Existing (Unmet) need

- In a given year, more than **1.5 million North Carolinians** over the age of 18 had a **mental illness** – and **1 in 5** of them **did not receive services** at all
- In the given year approximately **578,000 North Carolinians** over the age of 18 had **any substance disorder**, and **8 out of 9 needed but did not receive treatment** at a special facility for substance use
- In 2012 **suicide** became the leading cause of injury death in North Carolina and remained so in subsequent years.
  - For **veterans**, the average suicide rate was 2.4x that of the general population
- **SUD & incarceration**: 85% of the US prison population has an active substance use disorder or were incarcerated for a crime involving drugs or alcohol or drug use
- **Impact of the Pandemic**: Through August 2020, while NC has experienced a 19% decrease in overall Emergency Department visits, we have seen a 21% increase in Medical/Drug Overdose ED visits – largely driven by a 24% increase in opioid overdose ED visits.

COVID-19 Drivers, Outcomes, and Mitigations

1

Indirect Drivers Public Health Measures



Direct Drivers

3 **Mitigation strategies** include sustaining services, normalizing and managing crisis, and targeted interventions

- Policy modification, telehealth, provider guidance, and funding to support services
- Increased awareness, normalization, access to crisis services, resiliency
- Specific interventions for disproportionately impacted communities and outcomes

2

Individual's genetics, experiences, and coping mechanisms result in **varied outcomes**

Wellness Spectrum

- Increased frequency and intensity
- Anger and Hostility
- Excessive Use or Misuse
- Persistent Depression
- Violence towards self/others
- Situational loneliness, anxiety
- Withdrawal from community
- Inability to Cope
- Extreme Mood Changes
- Altered Perception
- Chronic and Persistent Illness