North Carolina Department of Health and Human Services
2001 Mail Service Center • Raleigh, North Carolina 27699-2001
Tel 919-733-4534 • Fax 919-715-4645

Michael F. Easley, Governor

Dempsey Benton, Secretary

January 15, 2008

The Honorable Beverly M. Earle, Chairman
Appropriations Subcommittee on Health and Human Services
North Carolina General Assembly
Room 634, Legislative Office Building
Raleigh, NC 27603

Dear Representative Earle:

Section 10.48 of S.L. 2007-323 (House Bill 1473), "NC Kids' Care," directs the Department of Health and Human Services to establish a program to expand access to health insurance for children in families with incomes above 200% of the federal poverty level. The Division of Medical Assistance is required to evaluate and make recommendations regarding the most cost-efficient and cost-effective method of developing and implementing a program to expand comprehensive health care benefits to children 0 to 18 with family incomes between 200% and 300% of the federal poverty level. An interim report to the General Assembly was due on January 1, 2008. An extension to the deadline was requested with a new deadline for submission of January 15, 2008. It is my pleasure to submit the interim report at this time.

Please direct all questions concerning this report to Mona Moon, Deputy Director for Research and Planning at the Division of Medical Assistance. She can be reached at 855-4100 or via e-mail at Mona.Moon@ncmail.net.

Sincerely,

Dempsey Benton

DB:mm

cc: Dan Stewart
William W. Lawrence, Jr., M.D.
Sharnese Ransome
Jennifer Hoffmann
Legislative Library (2)

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Michael F. Easley, Governor

Dempsey Benton, Secretary

January 15, 2008

The Honorable Bob England, M.D., Chairman
Appropriations Subcommittee on Health and Human Services
North Carolina General Assembly
Room 2219, Legislative Building
Raleigh, NC 27601

Dear Representative England:

Section 10.48 of S.L. 2007-323 (House Bill 1473), "NC Kids' Care," directs the Department of Health and Human Services to establish a program to expand access to health insurance for children in families with incomes above 200% of the federal poverty level. The Division of Medical Assistance is required to evaluate and make recommendations regarding the most cost-efficient and cost-effective method of developing and implementing a program to expand comprehensive health care benefits to children 0 to 18 with family incomes between 200% and 300% of the federal poverty level. An interim report to the General Assembly was due on January 1, 2008. An extension to the deadline was requested with a new deadline for submission of January 15, 2008. It is my pleasure to submit the interim report at this time.

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Michael F. Easley, Governor

Dempsey Benton, Secretary

January 15, 2008

The Honorable Verla Insko, Chairman
Appropriations Subcommittee on Health and Human Services
North Carolina General Assembly
Room 307-B1, Legislative Office Building
Raleigh, NC 27603

Dear Representative Insko:

Section 10.48 of S.L. 2007-323 (House Bill 1473), "NC Kids' Care," directs the Department of Health and Human Services to establish a program to expand access to health insurance for children in families with incomes above 200% of the federal poverty level. The Division of Medical Assistance is required to evaluate and make recommendations regarding the most cost-efficient and cost-effective method of developing and implementing a program to expand comprehensive health care benefits to children 0 to 18 with family incomes between 200% and 300% of the federal poverty level. An interim report to the General Assembly was due on January 1, 2008. An extension to the deadline was requested with a new deadline for submission of January 15, 2008. It is my pleasure to submit the interim report at this time.

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Michael F. Easley, Governor

Dempsey Benton, Secretary

January 15, 2008

The Honorable William Purcell, Co-Chair
Appropriations on Health and Human Services
North Carolina General Assembly
Room 625, Legislative Office Building
Raleigh, NC 27603

Dear Senator Purcell:

Section 10.48 of S.L. 2007-323 (House Bill 1473), "NC Kids' Care," directs the Department of Health and Human Services to establish a program to expand access to health insurance for children in families with incomes above 200% of the federal poverty level. The Division of Medical Assistance is required to evaluate and make recommendations regarding the most cost-efficient and cost-effective method of developing and implementing a program to expand comprehensive health care benefits to children 0 to 18 with family incomes between 200% and 300% of the federal poverty level. An interim report to the General Assembly was due on January 1, 2008. An extension to the deadline was requested with a new deadline for submission of January 15, 2008. It is my pleasure to submit the interim report at this time.

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Michael F. Easley, Governor

Dempsey Benton, Secretary

January 15, 2008

The Honorable Doug Berger, Co-Chair
Appropriations on Health and Human Services
North Carolina General Assembly
Room 622, Legislative Office Building
Raleigh, NC 27603

Dear Senator Berger:

Section 10.48 of S.L. 2007-323 (House Bill 1473), "NC Kids' Care," directs the Department of Health and Human Services to establish a program to expand access to health insurance for children in families with incomes above 200% of the federal poverty level. The Division of Medical Assistance is required to evaluate and make recommendations regarding the most cost-efficient and cost-effective method of developing and implementing a program to expand comprehensive health care benefits to children 0 to 18 with family incomes between 200% and 300% of the federal poverty level. An interim report to the General Assembly was due on January 1, 2008. An extension to the deadline was requested with a new deadline for submission of January 15, 2008. It is my pleasure to submit the interim report at this time.

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Legislative Library (2)

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2001 Mail Service Center • Raleigh, North Carolina 27699-2001
Tel 919-733-4534 • Fax 919-715-4645

Michael F. Easley, Governor

Dempsey Benton, Secretary

January 15, 2008

The Honorable Joe Hackney, Co-Chair
Joint Legislative Commission on Governmental Operations
North Carolina General Assembly
Room 2304, Legislative Building
Raleigh, NC 27601

Dear Representative Hackney:

Section 10.48 of S.L. 2007-323 (House Bill 1473), "NC Kids' Care," directs the Department of Health and Human Services to establish a program to expand access to health insurance for children in families with incomes above 200% of the federal poverty level. The Division of Medical Assistance is required to evaluate and make recommendations regarding the most cost-efficient and cost-effective method of developing and implementing a program to expand comprehensive health care benefits to children 0 to 18 with family incomes between 200% and 300% of the federal poverty level. An interim report to the General Assembly was due on January 1, 2008. An extension to the deadline was requested with a new deadline for submission of January 15, 2008. It is my pleasure to submit the interim report at this time.

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Tel 919-733-4534 • Fax 919-715-4645

Michael F. Easley, Governor

Dempsey Benton, Secretary

January 15, 2008

The Honorable Marc Basnight, Co-Chair
Joint Legislative Commission on Governmental Operations
North Carolina General Assembly
Room 2007, Legislative Building
Raleigh, NC 27601

Dear Senator Basnight:

Section 10.48 of S.L. 2007-323 (House Bill 1473), "NC Kids' Care," directs the Department of Health and Human Services to establish a program to expand access to health insurance for children in families with incomes above 200% of the federal poverty level. The Division of Medical Assistance is required to evaluate and make recommendations regarding the most cost-efficient and cost-effective method of developing and implementing a program to expand comprehensive health care benefits to children 0 to 18 with family incomes between 200% and 300% of the federal poverty level. An interim report to the General Assembly was due on January 1, 2008. An extension to the deadline was requested with a new deadline for submission of January 15, 2008. It is my pleasure to submit the interim report at this time.

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Tel 919-733-4534 • Fax 919-715-4645

Michael F. Easley, Governor

Dempsey Benton, Secretary

January 15, 2008

Lynn Muchmore, Director
Fiscal Research Division
Room 619, Legislative Office Building
Raleigh, NC 27601

Dear Mr. Muchmore:

Section 10.48 of S.L. 2007-323 (House Bill 1473), "NC Kids' Care," directs the Department of Health and Human Services to establish a program to expand access to health insurance for children in families with incomes above 200% of the federal poverty level. The Division of Medical Assistance is required to evaluate and make recommendations regarding the most cost-efficient and cost-effective method of developing and implementing a program to expand comprehensive health care benefits to children 0 to 18 with family incomes between 200% and 300% of the federal poverty level. An interim report to the General Assembly was due on January 1, 2008. An extension to the deadline was requested with a new deadline for submission of January 15, 2008. It is my pleasure to submit the interim report at this time.

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Sincerely,

Dempsey Benton

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Jennifer Hoffmann
Legislative Library (2)

Implementing NC Kids' Care

Interim Report to the 2007 General Assembly

State of North Carolina
Department of Health and Human Services
Division of Medical Assistance

January 1, 2008

Table of Contents

Executive Summary

Section 10.48 of Session Law 2007-323 (2007 Appropriation Act), entitled NC Kids' Care, requires the Department of Health and Human Services (Department) to identify "the most cost-efficient and cost-effective method for developing and implementing a program of comprehensive health care benefits within available funding for children ages 0 through 18 in families with annual incomes between two hundred percent (200%) and three hundred percent (300%) of the federal poverty level."

The legislation envisions consideration of various approaches for implementing an expansion of children's health care coverage via either the State Medicaid program or NC Health Choice and places particular emphasis on potential opportunities or obstacles arising from Congressional reauthorization of the State Children's Health Insurance Program (SCHIP).

The purpose of the SCHIP program is to provide health care coverage to children in families with income levels that exceed the Medicaid eligibility requirements, and thus has been the most commonly used vehicle by states to expand coverage to families with incomes above 200% of the federal poverty level (FPL).

As of the writing of this interim report, the SCHIP program is operating under a federal continuing resolution, because Congress and the President have not reached agreement on reauthorization legislation. Federal legislation to extend the program through March 31, 2009 was recently enacted. The Medicare, Medicaid and SCHIP Extension Act of 2007 (MMS), S. 2499 was approved by the US Senate and House and signed by the President in December. The MMS appropriates an additional $1.6 billion to eliminate funding shortfalls for the remainder of the 2008 federal fiscal year. This is good news for the State as North Carolina's SCHIP program, NC Health Choice, is anticipating a federal funding shortfall of $42.8 million, beginning in July 2008.

Although Congress has provided additional funding to prevent state shortfalls in the current year, long term reauthorization is still not likely for some time. Given the significant uncertainty surrounding federal funding and reauthorization, the SCHIP program is not currently a viable alternative for implementing NC Kids' Care. The Department will continue to monitor related federal legislation and reauthorization activity as the situation could change in the coming months.

In the meantime, the Department is revisiting its original plan to implement NC Kids' Care through a Medicaid waiver and/or state plan amendments. The Division of Medical Assistance (Division) is meeting with stakeholders to develop consensus regarding covered benefits and cost sharing requirements and hopes to include its recommendation in the final report to the General Assembly. In addition, the Division is seeking assistance from Mercer Government Human Services Consulting, a heath care consulting

firm, with respect to the waiver and program design and will request an updated actuarial estimate to support the recommended coverage package.

NC Kids' Care cannot be implemented, whether through a Medicaid or SCHIP expansion, or demonstration waiver, without the approval of the Centers for Medicare and Medicaid Services (CMS). The process will take time to complete and will almost certainly involve negotiation over the structure and elements of the proposal. Furthermore, the structure of a limited benefit program will likely be substantially different from current coverage mechanisms that the Department implements. Significant systems modifications or procurement of an expert vendor will be necessary to implement such a program. Finally, the federal match rate for SCHIP may allow NC to serve substantially more children with appropriated dollars than a Medicaid waiver. For these and other reasons, any options for implementing Kids' Care will require careful consideration; SCHIP expansion will rise amongst the most attractive methods, if NC receives its fair share of federal allocations. As such, if the outlook for implementation under SCHIP becomes more favorable during the process, the Department will reconsider its options.

Although implementing NC Kids' Care to provide coverage to more low income children is an important step to improving health care access in the state, ensuring ongoing coverage for children currently enrolled in NC Health Choice is the top priority. If Congress fails to provide sufficient funding to continue SCHIP coverage and support program growth, implementation of NC Kids' Care is expected to be further delayed.

Implementing NC Kids' Care

Section 10.48 of Session Law 2007-323 (2007 Appropriation Act), entitled NC Kids' Care, requires the Department of Health and Human Services (Department) to identify "the most cost-efficient and cost-effective method for developing and implementing a program of comprehensive health care benefits within available funding for children ages 0 through 18 in families with annual incomes between two hundred percent (200%) and three hundred percent (300%) of the federal poverty level."

The legislation envisions consideration of various approaches for implementing an expansion of children's health care coverage via either the State Medicaid program or NC Health Choice. Particular emphasis is placed on consideration of potential opportunities or obstacles arising from Congressional reauthorization of the State Children's Health Insurance Program (SCHIP). In addition, the legislation sets out a number of specific elements or policies for consideration by the Department.

The full text of the special provision follows:

> **"NC KIDS' CARE**
>
> **SECTION 10.48.(a)** Of the funds appropriated in this act to the Department of Health and Human Services, Division of Medical Assistance, the sum of three hundred sixty-eight thousand dollars ($368,000) for the 2007-2008 fiscal year shall be used by the Department of Health and Human Services to produce a report that identifies the most cost-efficient and cost-effective method for developing and implementing a program of comprehensive health care benefits within available funding for children ages 0 through 18 in families with annual incomes between two hundred percent (200%) and three hundred percent (300%) of the federal poverty level. The report shall consider and address the following:
>
> (1) Congress' reauthorization of the State Children's Health Insurance Program (SCHIP) with respect to:
>
> a. The amount of federal funds authorized for each of the fiscal years covered in the reauthorization;
>
> b. The number of fiscal years that federal funding awarded to the states remains available to each state;
>
> c. The adequacy of the formula by which federal funds are distributed to the states; and
>
> d. The ability of states to expand SCHIP coverage to children whose family incomes exceed two hundred percent (200%) of the federal poverty level.
>
> The Department shall determine whether the most effective use of State funds is to develop a program that expands access to health insurance for children whose family income exceeds two

hundred percent (200%) of the federal poverty level through NC Health Choice or the State Medical Assistance Program.

(2) Eligibility and benefits are not an entitlement, are for legal residents of North Carolina, and are subject to availability of State and federal funds, and State and federal requirements.

(3) The most cost-effective use of limited State funds to offer health care services to children in families between two hundred percent (200%) and three hundred percent (300%) of the federal poverty level.

(4) Children enrolled in the program must be ineligible for Medicaid, Medicare, or other government-sponsored health insurance. The Department shall study whether children must also be without private health insurance for a specified amount of time, e.g. six months.

(5) The health care benefits covered in the proposed expansion program shall not exceed the benefits currently covered by the NC Health Choice.

(6) The establishment of cost-sharing measures for the families of children with an income above two hundred percent (200%) of the federal poverty level, including:

a. A monthly premium per child that is at an optimal level that simultaneously is affordable, encourages participation by families, controls costs, and provides revenue to reduce the cost of the program to the State. The amount of the premium may increase as income increases above two hundred percent (200%) of the federal poverty level.

b. Increased co-payments and cost-sharing that are affordable and sufficient to control costs, while not discouraging families from seeking and continuing prescribed treatment for children.

c. A deductible that is to be applied to certain health care benefits.

d. A limit on out-of-pocket expenses that is no more than five percent (5%) of family income.

(7) The establishment of a comprehensive annual benefit limit per child that is no more than the current annual benefit limit under NC Health Choice.

(8) The most cost-effective and efficient way of administering and managing enrollment in the program and the collection of premiums. This may include having the current administrator of NC Health Choice be the entity to collect premiums, or designating some other benefit management or administrative entity to do so, including the Department.

SECTION 10.48.(b) Not later than January 1, 2008, the Department shall submit an interim report of its findings and recommendations to the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, the Joint Legislative Commission on Governmental Operations, and the Fiscal Research Division. The Department shall submit its final report not later than February 1, 2008. It is the intent of the General Assembly to review the Department's recommendations before the Department implements a program to expand access to health insurance to children above two hundred percent (200%) of the federal poverty level effective July 1, 2008, or upon approval of all required federal waivers, whichever occurs later.

SECTION 10.48.(c) Of the funds appropriated in this act to the Department of Health and Human Services, the sum of seven million dollars ($7,000,000) for the 2008-2009 fiscal year shall be used to implement a program to expand access to health insurance to children above two hundred percent (200%) of the federal poverty level effective July 1, 2008."

This interim report will address the current status and related issues for each of the eight subdivisions of Section 10.48(a).

SCHIP Reauthorization/Other Options for Implementation – Sec. 10.48(a)(1)

SCHIP Reauthorization – The purpose of the SCHIP program is to provide health care coverage to children in families with income levels that exceed the Medicaid eligibility requirements. States also receive an enhanced or higher federal matching rate for SCHIP than for Medicaid, and thus the program has been the most commonly used vehicle by states to expand coverage to families with incomes above 200% of the federal poverty level (FPL). Currently 19 states provide coverage for children with family incomes above 200% of poverty, with 11 of the 19 covering children above 250% of FPL.[1]

As of the writing of this interim report, the SCHIP program is operating under a federal continuing resolution, as Congress and the President have not reached agreement on reauthorization legislation. To date the President has vetoed two reauthorization bills, H.R. 976 and H.R. 3963, with the most recent veto occurring on December 12, 2007. The major points of contention are the total amount of funding and various eligibility related policies.

Thus far state allotments under the continuing resolutions have been equal to the amounts appropriated last year. A report issued by the Congressional Research Service indicates that as many as 19 states will exhaust their federal funding for SCHIP, including funds

[1] *Children's Health Insurance Program Reauthorization Act of 2007(CHIPRA)*, The Kaiser Commission on Medicaid and the Uninsured, October 2007. Accessed at http://www.kff.org/medicaid/7701.cfm.

remaining from prior year allotments, and experience shortfalls totaling $1.16 billion before the end of the federal fiscal year.[2]

North Carolina is one of the shortfall states, projecting a federal funding deficit of as much as $42.8 million. Although NC Health Choice will have sufficient funds to operate through the end of the state fiscal year in June, the federal shortfall will occur in early to mid July 2008.

Federal legislation to extend the SCHIP program through March 31, 2009 was recently enacted. The Medicare, Medicaid and SCHIP Extension Act of 2007 (MMS), S. 2499 was approved by the US Senate and House and signed by the President in December. The MMS appropriates an additional $1.6 billion to eliminate funding shortfalls for the remainder of the 2008 federal fiscal year. The Division has not yet been notified of an adjustment to the State's allotment for the remainder of the federal fiscal year, but we expect to receive sufficient funding to cover the shortfall based on a report issued by the Federal Funds Information for States (FFIS) organization.[3]

Although there have been some reports that the House may attempt to override the latest veto in late January, further consideration of reauthorization legislation may be delayed for several months given the program extension through March 2009.

The lack of long term reauthorization makes it impossible to fully address the detailed issues outlined in the budget special provision. However, the Congressional debate has provided some insights into what we can expect the program to look like under reauthorization. Congress is considering a number of policy and programmatic changes to the SCHIP program in an effort to address concerns expressed by the President, including:

1. Renewed focus on coverage for the lowest-income children – States will likely be prohibited from extending coverage to children in families with incomes above 300% of FPL (with perhaps a couple exceptions for states that already provided coverage above this level). Financial incentives may be provided to encourage states to enroll uninsured eligibles with the lowest incomes.
2. Increased measures to limit substitution of private insurance coverage (crowd-out) – States will likely be required to implement a variety of practices designed to minimize crowd-out, including requiring eligibles to demonstrate a lack of insurance for a specified period, perhaps as long as a year, immediately prior to enrollment. States will also be encouraged to

[2] Peterson, Chris L., *FY2008 SCHIP Allotments and Projected Shortfalls*, CRS Report for Congress, Updated December 12, 2007.
[3] *The VIP Series*, Volume 7, No. 2, December 2007, Federal Funds Information for States. See www.ffis.org.

offer "premium assistance" programs to cover children via employer sponsored insurance in lieu of enrolling them in the public coverage.

3. Citizenship documentation requirements similar to Medicaid – Concerns over the enrollment of ineligible undocumented immigrants will likely result in the enactment of citizenship documentation requirements similar to the Medicaid program, but with new options for matching data with the Social Security Administration.
4. Eliminate coverage for childless adults – At least four states currently cover childless adults via SCHIP demonstration waivers. At a minimum, the federal government will likely be prohibited from issuing any new waivers to extend coverage to childless adults, but states may also face a reduction in federal match for this population as well as a requirement to terminate coverage prior to the end of the demonstration.

Although Congress provided additional funding to prevent state shortfalls in the current year, long term reauthorization is still not expected in the near future. Given the significant uncertainty surrounding federal funding and reauthorization, the SCHIP program is not currently a viable alternative for implementing NC Kids' Care. The Department will continue to monitor related federal legislation and reauthorization activity as the situation could change in the coming months.

Other Options for Implementation – Rather than wait until agreement is reached on SCHIP reauthorization, the Department is revisiting its original plan to implement NC Kids' Care through a Medicaid waiver and/or state plan amendments. An overview of various research and demonstration waivers and other options for changes under the Medicaid and SCHIP state plans is included in the appendix. There are advantages and disadvantages associated with each option, and it is important to note that most often states have combined expansion coverage for children with other changes to their Medicaid or SCHIP programs in developing their demonstration.

The Division of Medical Assistance (Division) is meeting with stakeholders to develop consensus regarding covered benefits and cost sharing requirements and hopes to include its recommendation in the final report to the General Assembly. In addition, the Division is seeking assistance from Mercer Government Human Services Consulting (Mercer), a health care consulting firm, with respect to the waiver and program design and will request an updated actuarial estimate to support the recommended coverage package.

Eligibility Requirements and Funding Availability – Sec. 10.48(a)(2)

Entitlement Status/Funding – As recommended by the Governor, NC Kids' Care is not intended to be an entitlement program. Should it be implemented as a Medicaid expansion program, the Department will request a waiver allowing the state to limit enrollment to ensure that expenditures do not exceed available funds.

Residency and Citizenship – The federal Deficit Reduction Act of 2005 requires United States citizens to provide "satisfactory documentary evidence" of their citizenship when applying for or renewing Medicaid coverage. North Carolina implemented this requirement as part of Medicaid eligibility process through local Division of Social Services agencies. A similar requirement is likely to be enacted as part of the SCHIP reauthorization legislation.

The citizenship documentation requirements are designed to ensure that ineligible undocumented immigrants are not enrolled in the program. Because NC Kids' Care will be implemented either through Medicaid or SCHIP, residency requirements for the program will be determined in the same manner.

Cost-Effective Use of State Funds – Sec. 10.48(a)(3)

The legislation does not define the term "cost-effective" for the purposes of determining "the most cost-effective use of limited State funds." Although implementing NC Kids' Care under SCHIP may allow the State to receive a higher federal matching rate for the program, the total cost per child and the amount of the public subsidy should also be considered.

The total cost per child (i.e. federal, state, and enrollee shares combined) will be controlled by providing a basic benefit package focusing on preventive care and requiring enrollees to share in the cost of services by paying co-payments, deductibles and/or coinsurance. The amount of the public subsidy (i.e. federal and state shares combined) will depend on the level of monthly premiums paid by enrollees (i.e. higher premiums yield lower public subsidy). The Department will try to balance these elements in developing NC Kids' Care to ensure cost-effectiveness for the state as well as for covered children and their families.

Eligibility for and Coverage under Other Insurance Plans – Sec. 10.48(a)(4)

Bare Period – As discussed under the section on SCHIP reauthorization, Congress is expected to enact new requirements or practices to limit the substitution of private insurance coverage with public coverage (i.e. crowd-out). These measures could include a requirement that eligibles have no other insurance coverage immediately prior to enrollment for a period of up to a year (i.e. a bare period). In addition, the Centers for Medicare and Medicaid Services (CMS), the federal oversight agency, has expressed its intent to require similar measures to limit crowd-out in considering applications for Medicaid waivers. The Department will comply with any required waiting period, but will also seek flexibility to (1) set the length of the bare period to ensure eligible children do not needlessly wait for coverage to become effective and (2) enroll children whose private sector coverage is terminated through no fault of their own.

NC Health Choice Buy-In Program – G.S. 108A-70.21(g) allows any NC Health Choice enrollee who loses eligibility due to an increase in family income above 200% of FPL and up to 225% of FPL to continue coverage (i.e. same benefits and copayments) for up to a year by paying the full cost of the premium. Participation in the "buy-in" program may be considered eligibility for "other government-sponsored health insurance" and would therefore render the child ineligible for NC Kids' Care.

Given the option, some families may prefer to continue coverage under the NC Health Choice benefit package at the full premium cost, while others may prefer to move to NC Kids' Care receive with a reduced benefit package and partial premium subsidy. In addition to the differences in premiums and benefits, families will also have to consider any required bare or uninsured period before deciding which program they prefer. The Department is exploring options relative to such situations and will offer a recommendation at a later date.

Health Benefits and Coverage Policies – Sec. 10.48(a)(5)

NC Kids' Care as recommended by Governor Easley in the 2007 Legislative Session is intended to provide health care coverage via a reduced or limited benefit plan to children in families with incomes between 200% and 300% of FPL. The program is based on a recommendation of the NC Institute of Medicine (IOM) Task Force on Covering the Uninsured to establish a "Medicaid Light" benefit for parents and their children up to 300% of FPL. In its request to the General Assembly, the Department requested flexibility to develop the program, specify covered services, set coverage limitations, and establish cost sharing requirements to facilitate implementation.

Action for Children (AFC), a nonprofit devoted to child advocacy and research in North Carolina, proposed an alternative plan, Carolina Cares for Children, for consideration by the General Assembly. Both the IOM and AFC plans propose reduced benefit coverage relative to the NC Health Choice program and focus on preventive care. A side by side comparison of the IOM's Medicaid Light and AFC's Carolina Cares for Children proposals can be found in the appendix.

During the session, the Division, Action for Children and other stakeholders began discussions on how best to merge the proposals. Those discussions have recently resumed and the Department hopes to outline the recommended benefits and coverage policy in its final report to the General Assembly.

Cost Sharing Requirements – Sec. 10.48(a)(6)

NC Kids' Care will impose higher cost sharing for enrollees than NC Health Choice. Both the IOM and AFC plans propose multiple cost sharing mechanisms, including

premiums, co-payments, deductibles and coinsurance, but otherwise use different approaches. A side by side comparison of the IOM's Medicaid Light and AFC's Carolina Cares for Children proposals can be found in the appendix.

The IOM proposal assumes a lower average monthly premium and requires 20% coinsurance on most non-preventive services. The AFC proposal employs a higher average monthly premium and limits additional cost sharing to co-payments and a $500 deductible for certain services. Under the IOM proposal, enrollees pay less up front via premiums, but may face higher out of pocket costs as they use services. Under the AFC proposal, enrollees pay more in premiums up front, regardless of whether they seek treatment, in exchange for the predictability of co-payments and a deductible as they use services.

Resolving the differences in the cost sharing approaches is a top priority as the Division resumes discussions with Action for Children. The Division is working with Mercer to help evaluate the options for cost sharing and determine the best approach to encourage appropriate utilization of services, while maintaining affordability for the target population.

Annual Benefit Limit – Sec. 10.48(a)(7)

Coverage policies and limitations for NC Health Choice are set out in statute under G.S. 108A-70.21 and are equivalent to the coverage polices and limitations of the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan, unless otherwise provided in the statute. Currently there is no annual benefit limit for NC Health Choice, but there is a $5 million lifetime benefit maximum.

The limited benefit plan recommended by the NC Institute of Medicine included an annual benefit limit of $1 million. The Department has not finalized the annual benefit limit for NC Kids' Care, but is exploring options as part of its overall analysis of the cost sharing requirements.

Program Administration – Sec. 10.48(a)(8)

Until the Department has a better sense of whether NC Kids' Care will be implemented via Medicaid or SCHIP, we cannot identify the most cost-effective and efficient administrative mechanism for the program.

Implementing the coverage policies and cost sharing requirements for NC Kids' Care will require modifications to the Medicaid Management Information System (MMIS). However, limitations of the current system will affect the Division's ability to bill for and collect enrollee premiums. The Division is exploring options for the development of a

stand alone premium tracking system to support NC Kids' Care as well as other initiatives that require similar cost sharing. The cost effectiveness of changes to MMIS should be considered in light of the Division's plans to implement a replacement MMIS in the next couple of years.

NC Health Choice is currently administered by the State Health Plan (SHP) via a contract with Blue Cross Blue Shield (BCBS) in accordance with State law. Should NC Kids' Care be implemented via an SCHIP expansion or waiver, it is unclear whether the SHP contract could be amended to include NC Kids' Care, but a statutory change would likely be required. In addition, the SHP is transitioning coverage for state employees to a preferred provider organization (PPO) in lieu of the indemnity plan effective July 1, 2008. The change may also make administration of NC Kids' Care via the current administrative arrangement a challenge, as the coverage, cost sharing and other program elements will differ from both NC Health Choice and the PPO.

The Department is also considering a separate contract with a third party administrator. This option should facilitate the collection of premiums and future integration with the replacement MMIS, but may require significant set-up costs to accommodate the benefits and coverage policy.

Conclusion

NC Kids' Care cannot be implemented, whether through a Medicaid or SCHIP expansion, or demonstration waiver, without the approval of CMS. Until the SCHIP program is reauthorized, the Department will plan for and pursue implementation under the Medicaid program. The process will take time to complete and will almost certainly involve negotiation over the structure and elements of the proposal. Should the outlook for implementation under SCHIP become more favorable during the process, the Department will reconsider its options.

Although implementing NC Kids' Care to provide coverage to more low income children is an important step to improving health care access in the state, ensuring ongoing coverage for children currently enrolled in NC Health Choice is the top priority. If Congress fails to provide sufficient long term funding to continue SCHIP coverage and support program growth, implementation of NC Kids' Care is expected to be further delayed.

Appendix

Kids' Care[4] Coverage Options

I. Section 1115 Medicaid Research and Demonstration Waivers:

States administer their Medicaid and SCHIP programs subject to requirements and options established under federal law. Section 1115(a) of the Social Security Act (Act) gives the Secretary of Health & Human Services (HHS) discretionary authority, subject to the requirements of the Act, to consider and approve research and demonstration waiver proposals submitted by states that further the purposes of their Medicaid and SCHIP programs. HHS's waiver authority allows states to use federal funds to test new methods of administering their Medicaid and SCHIP programs to adapt to the changing health care environment. Knowledge derived and lessons learned from these research and demonstration waivers are used by HHS to make improvements in achieving the objectives of the Act.

Medicaid 1115 Research and Demonstration Waivers – Since Section 1115 demonstration waiver guidance was published by the Health Care Financing Administration (HCFA), now the Centers for Medicare and Medicaid Services (CMS), in the Federal Register in 1994[5], the application and approval process was made more accessible, and the use of Section 1115 demonstration waivers became more prevalent. State Medicaid programs have used the waiver authority to reduce benefits or increase premiums or cost sharing beyond federal standards and to contract with managed care organizations. The federal law requirements most commonly waived under Section 1115 Medicaid demonstrations fall into the following seven categories[6].

- Statewide-ness: allowing the states to make changes in some areas of the state, but not all.
- Comparability: allowing the states to provide different sets of benefits to different groups of beneficiaries.
- Eligibility: allowing states to make changes to eligibility criteria and standards to limit coverage or to expand coverage to groups otherwise excluded from Medicaid under federal law (e.g., adults without dependent children).
- Freedom of choice: allowing states to restrict the choice of providers and implement mandatory managed care enrollment for certain categories of beneficiaries.
- Managed care organizations: allowing states to contract with delivery systems not otherwise allowed.

[4] NC Kids' Care Program is intended to provide health care assistance for uninsured children with family incomes between 200% and 300% FPL.
[5] 59 FR 49349, September 27, 1994
[6] Exploring a New Option: Section 1115 Demonstration Waivers under SCHIP, Gabriela Alcalde, MPH, NCSL

- Reimbursement: allowing for some changes in payment requirements.
- Enrollment caps.

SCHIP 1115 Research and Demonstration Waivers – The Section 1115 SCHIP research and demonstration waivers provide states with the flexibility to design their SCHIP program to achieve programmatic goals and objectives not otherwise permitted under federal law and also receive an enhanced federal match rate. HCFA (now CMS) released guidance on July 31, 2000[7] describing the prerequisites states must meet prior to submitting a waiver proposal and the factors CMS will consider in its review of proposal. According to CMS guidance, no SCHIP waiver proposals will be accepted unless the state can provide the following assurances:

- The state must prove it is covering children to age 19 with family incomes up to 200 percent of the federal poverty level (FPL). The state may not have a waiting list, or otherwise restrict enrollment of eligible children.
- The state must assure it will provide coverage for lower-income populations before covering the higher-income populations made eligible by the demonstration project. Further, the state cannot cover any group at a higher FPL than it covers for its targeted low-income children.
- The state must demonstrate that it is promoting enrollment and retention of currently eligible children through its existing application and re-determination processes.
- For states that are interested in covering populations other than targeted low-income children, the state must have implemented at least three of the following five eligibility policies:
    1. Use a joint, mail-in application and common application process for SCHIP and Medicaid;
    2. Eliminated assets tests;
    3. 12-month continuous eligibility;
    4. Presumptive eligibility; and/or
    5. Simplified its procedures for redetermination of coverage.

States that are currently operating under a SCHIP 1115 demonstration waiver have used the waiver authority to:

- Expand coverage to children, (e.g., children ages 19-21 who are otherwise eligible for SCHIP).
- Adopt new and innovative outreach strategies,
- Provide services that improve the quality of care and health outcomes of the recipients.

[7] Dear State Health Official Letter, July 31, 2000. See www.cms.gov.

- Extend coverage to related populations (e.g., pregnant women with incomes above 185% of FPL and parents or adult caretakers above 100% of FPL). The CMS Guidance cautions that CMS will only consider such requests to extend SCHIP to populations other than uninsured children when it is assured that proposal seeks to use SCHIP funds for coverage related to the purpose of SCHIP.

The CMS Guidance states that no waivers will be considered that propose to use waiver authority to:

- Reduce benefits below benchmark levels;
- Impose cost-sharing above levels specified under SCHIP;
- Include coverage of a nonpregnant, childless adult;
- Cover groups such as state employees, children in institutions for mental illness or children already insured with comprehensive health plans because this could lead to federal funds being substituted for state or private funds;
- Cover Medicaid-eligible children in a separate child health program; or
- Waive the ten percent cap on administrative expenditures.

Submission Requirements for Section 1115 Medicaid SCHIP Research and Demonstration Waiver Proposals

1. Concept development and assurance of Budget Neutrality (consult with CMS)
    - A Medicaid Section 1115 demonstration proposal must be cost neutral, meaning that the state must finance the demonstration proposal with existing levels of federal funding (i.e, a budget neutrality cap). Proposals that seek to expand coverage or enhance services must use funds from savings created in the existing Medicaid program or by redirecting existing Medicaid funds. Waiver expansions that cover groups that could be covered under Medicaid without a waiver are considered “pass throughs”. States do not have to find offsetting savings to cover such groups, but their waiver payments still are brought under the budget neutrality cap[8].
    - In the case of SCHIP, budget neutrality is defined as "allotment neutrality." States can spend up to their individual SCHIP funds allotment. Reallocated funds from previously unspent SCHIP allotments will not be included in this amount.

2. Develop evaluation design:
    - With all Section 1115 research and demonstration proposals, states must identify their research and demonstration objectives, and explain what

[8] *New Directions for Medicaid Section 1115 Waivers: Policy Implications of Recent Waiver Activity*, Kaiser Commission on Medicaid and the Uninsured, March 2005.

lessons will be learned and how the demonstration will further the goals of the program. For example, with respect to an SCHIP research and demonstration waiver, the proposal must explain how expanded coverage of the core population (children with family incomes up to 200% of FPL) will be improved or promoted through the use of the research and demonstration authority.

- The evaluation design must be meaningful, unobtrusive and use the appropriate techniques and methodology.

3. Provide public notice; states must facilitate public involvement; CMS must approve of state's process for providing such input

4. Confer with American Indians/Alaska Natives (AI/AN) Tribes and Tribal organizations;

5. Develop State plan amendment (if demonstration project proposal will affect current SCHIP population, an SCHIP amendment must be submitted; if the demonstration project will affect current Medicaid population, a Medicaid amendment must be submitted);

6. Submit research and demonstration proposal (electronic copy and three hard copies to CMS);

7. Implementation and evaluation; and

8. During the 6-month period ending one year before a Section 1115 waiver would expire, a state may submit its request for an extension of up to three years. The waiver extensions must be on the same terms and conditions that applied to the waiver before its extension.

Health Insurance Flexibility and Accountability (HIFA) Demonstration Waivers

In August of 2001, the US Department of Health and Human Services (HHS) invited states to participate in a new approach to an 1115 waiver of Medicaid and SCHIP called a Health Insurance Flexibility and Accountability (HIFA) initiative. The primary goal of a HIFA initiative is to provide states with the flexibility to waive certain requirements of the Medicaid and SCHIP laws to in order to expand health insurance coverage using current levels of Medicaid and SCHIP resources. Under a HIFA demonstration, states have the flexibility to determine their own approach to increasing health insurance coverage. However, HHS will give priority to broad statewide approaches that use Medicaid and SCHIP resources to maximize private health insurance coverage options for populations with family incomes below 200% of the Federal poverty level (FPL).

Target Populations – The populations that may be covered under a HIFA waiver include:

- **Mandatory populations**: Includes eligibility groups that a State must cover under Medicaid or SCHIP;
- **Optional populations**: Includes eligibility groups that a State may cover under a Medicaid or SCHIP state plan (even if the specific group isn't currently covered); and
- **Expansion populations**: Includes individuals who can only be covered in an eligibility group under Medicaid or SCHIP through an 1115 waiver (e.g., nondisabled childless adults).

Eligibility limits – The HIFA demonstration targets populations with incomes below 200%, but does not limit the upper eligibility level. Income is defined in the HIFA guidelines as "gross income". However, Arizona is operating under approved HIFA waiver using "net income", indicating that this is a flexible issue. State requesting the use of HIFA waiver authority to extend Medicaid and SCHIP above 200% will be expected to demonstrate in the submission that:

- Focusing resources on populations below 200% of FPL is unnecessary because the State already has high coverage rates in this income range;
- Covering individuals above 200% of FPL under the demonstration will not induce individuals with private coverage to drop their current coverage.

Benefit Package – The HIFA demonstration provides states with flexibility to modify current benefit packages for optional or expansion SCHIP and Medicaid populations. Flexibility under a HIFA demonstration is greatest for expansion groups. For optional groups, which would include the proposed Kids' Care eligibility group, the flexibility is limited to one of the benefit packages identified in Title XXI (SCHIP benchmark plans).

Cost Sharing – Cost sharing for optional and expansion SCHIP and Medicaid populations should not exceed 5 percent of the family's income. In cases where the entire family is covered, this guideline does not apply to cost sharing not attributable to individual family members, such as a family premium.

Financing and Budget Neutrality – As with other 1115 waiver proposals, HIFA initiatives must be cost neutral to Medicaid to ensure that demonstration projects do not increase federal funding over what would have been spend under current law program requirements. Each demonstration operates under a budget neutrality agreement that will limit federal financial payments of the life of the demonstration and is negotiated prior to approval of the waiver in accordance with federal HIFA guidance. Premium collections and other offsets can be used to reduce overall program expenditures.

Emphasis on Private Health Coverage – Under the HIFA demonstration initiative, HHS strongly encourages State proposals that integrate, or at a minimum, coordinate, Medicaid and SCHIP funding with private health insurance options. States are permitted to define the benefit package and cost sharing for optional populations in support of increased use of private group health plan premium assistance programs.

II. State Plan Options:

Expansion of Medicaid eligibility – Section 1902(r)(2) of the Social Security Act permits states to extend Medicaid coverage to certain groups of categorically eligible beneficiaries (pregnant women, children under the age of nineteen, and qualified Medicare beneficiaries) using less restrictive income and asset eligibility requirements than those that are applied under traditional Medicaid.

Under the Deficit Reduction Act:

Flexibility in Cost Sharing – Section 1916A of the Social Security Act permits states to impose premiums and cost sharing for any group of individuals for any type of service through Medicaid State Plan amendments, subject to specific restrictions. Cost sharing may be imposed for individuals in families with incomes above 150% FPL with the following limitations: (1) cost sharing may not exceed 20% for any item or service and (2) total cost sharing is capped at 5% family income. No premiums may be imposed on children under age 18.

Flexibility in Benefits – Section 1937 of the Social Security Act permits states to provide Medicaid coverage to state-specified groups through enrollment in benchmark and benchmark-equivalent coverage. States can only exercise this option for eligibility groups that were established under the state plan on or before the date of enactment of this option.

	NC Institute of Medicine	Action for Children
Eligibility	Children Under Age 19 @ 200-300% FPL	Children Under Age 19 @ 200-300% FPL Children Under Age 19 Over 300% FPL as a Buy-In Option
Annual Benefit Limit	$1 million	None
Out of Pocket Max	$2,500/Person on Coinsurance	$1,000/Child; $2,000/Family
Deductible	$100, applies to inpatient hospitalization only	$500
Premium	Sliding scale, estimated average = $23.77/ month for incomes 201% to 300% FPL	Sliding scale, estimated average = $65.50/month for incomes 201% to 300% FPL
Reimbursement	Medicaid Rates	Medicare, except pharmacy services at Medicaid

	IOM: Medicaid Light					AFC: Carolina Cares for Children				
Category of Service	Covered Service	Co-Payment	Coinsurance	Deductible	Benefit Limit	Covered Service	Co-Payment	Coinsurance	Deductible	Benefit Limit
Inpatient Physical Health	Yes	$0	20%	$100 Combined with Inpatient Behavioral Health	$10,000 limit/ calendar year Combined with Inpatient Behavioral Health	Yes	$0	None	Deductible Applies, then 100% coverage	
Skilled Nursing Facility	No					Yes	$0	None	Deductible Applies, then 100% coverage	
Outpatient Physical Health	Yes	$0				Yes				
Medical / Surgery	Yes	$0	20%			Yes	$30	None	Waived	
PT, OT, & Speech Therapy	Yes	$0	20%		Limit 25 visits per calendar year	Yes	$30/visit for first 3 visits, waived afterwards with OK from medical home	None	Waived	
Emergency Room	Yes	$100 (waived if admitted)	20%			Yes	$10, $100 if determined non-emergent	None	Waived	
Primary Care Physician	Yes	$20			5 physician visit/year (add'l wellness visit allowed, according to periodicity schedule, & add'l visits allowed if actively participating in CCNC and approved by PCP)	Yes	$10, none if EPSDT or preventive care	None	Waived	
Specialist Physician	Yes	$40			Falls under 5 visit limit	Yes	$30	None	Waived	

	IOM: Medicaid Light					AFC: Carolina Cares for Children				
Category of Service	**Covered Service**	**Co-Payment**	**Coinsurance**	**Deductible**	**Benefit Limit**	**Covered Service**	**Co-Payment**	**Coinsurance**	**Deductible**	**Benefit Limit**
Inpatient Behavioral Health	Yes		20%	$100 Combined with Inpatient Behavioral Health	$10,000 limit/ calendar year Combined with Inpatient Behavioral Health	Yes	$0	None	Deductible Applies, then 100% coverage	
Outpatient Behavioral Health	Yes	$40			20 visits per calendar year	Yes	$30/visit	None	Waived	6 visits allowed without diagnosis, 26 visits annually
Behavioral Health Other	**No**					**No**				
Pharmacy (Tiered Co-payments)	Yes				6 Total Scripts per Month					
Generic		$5			See monthly limit	Yes	$0	None	Waived	
Brand		$30			See monthly limit	Yes	$20	None	Waived	
Brand Non-formulary		$60			See monthly limit	Yes	$20	None	Waived	
Family Planning	Yes				Contraceptives covered (doctors visit under 5 visit limit or wellness visit), not included in 6 script limit	Yes	$0	None	Deductible applies, then 100% coverage	
Case Management	Yes				By CCNC only	Yes	$0	None	Waived	By CCNC only
Home Health	**No**					Yes	$0	None	Deductible Applies, then 100% coverage	
Personal Care	**No**					Yes	$0	None	Deductible Applies, then 100% coverage	210 minutes per day, 60 hours per month
School Based Services	Yes, to extent school is provider of covered services					Yes	$0	None	Deductible Applies, then 100% coverage	
Lab & Radiology	Yes		20%		Requires pre-authorization of MRI/PET scans	Yes	$0	None	Deductible Applies, then 100% coverage	
Dental	No					No				

	IOM: Medicaid Light					AFC: Carolina Cares for Children				
Category of Service	**Covered Service**	**Co-Payment**	**Coinsurance**	**Deductible**	**Benefit Limit**	**Covered Service**	**Co-Payment**	**Coinsurance**	**Deductible**	**Benefit Limit**
DME / Supplies	Yes		20%		$500 limit with prior approval (diabetic supplies unlimited)	Yes	$0	None	Deductible Applies, then 100% coverage	
EPSDT	Well visits and immuniz. only					Yes, Preventive Care	$0	None	Waived	
Ambulance	Yes	$150, waived if admitted	20%			Yes	$0, $100 if determined non-emergent	None	Deductible Applies, then 100% coverage	
Maternity	No					No				
Podiatry	Yes	$40			Subject to physician visit limit	Yes as specialty physician				
Optometry	Yes	$40			Eye exam subject to physician visit limit	Yes	0	None	Deductible Applies, then 100% coverage	One exam annually; with prior approval, one set of lenses annually and one set of frames every 24 months