

HEALTH CARE NC (HCNC)

Background and Overview of the NC
LWV HCLAT Project, 2018

What is the Medicaid Gap?

(We're calling it the "health care coverage gap")

- Most people don't know that only 30% of adults with low income or no income qualify for Medicaid in NC
- That means that 70% of these adults don't qualify

Two main categories of people who do not qualify for Medicaid

- Childless adults with income less than 100% of Federal Poverty Level (FPL, \$12,060/year)
- Parents with family income between 44% and 100% FPL (\$7,145 to \$16,240 for a single mother with one child)
- These people are in the health care coverage gap

Why is it called a “Gap?”

Because you have to make more than 100% FPL to qualify for subsidized ACA insurance, but if you make less than 100% FPL, you have no way to get any help paying for health care coverage. You have nothing.

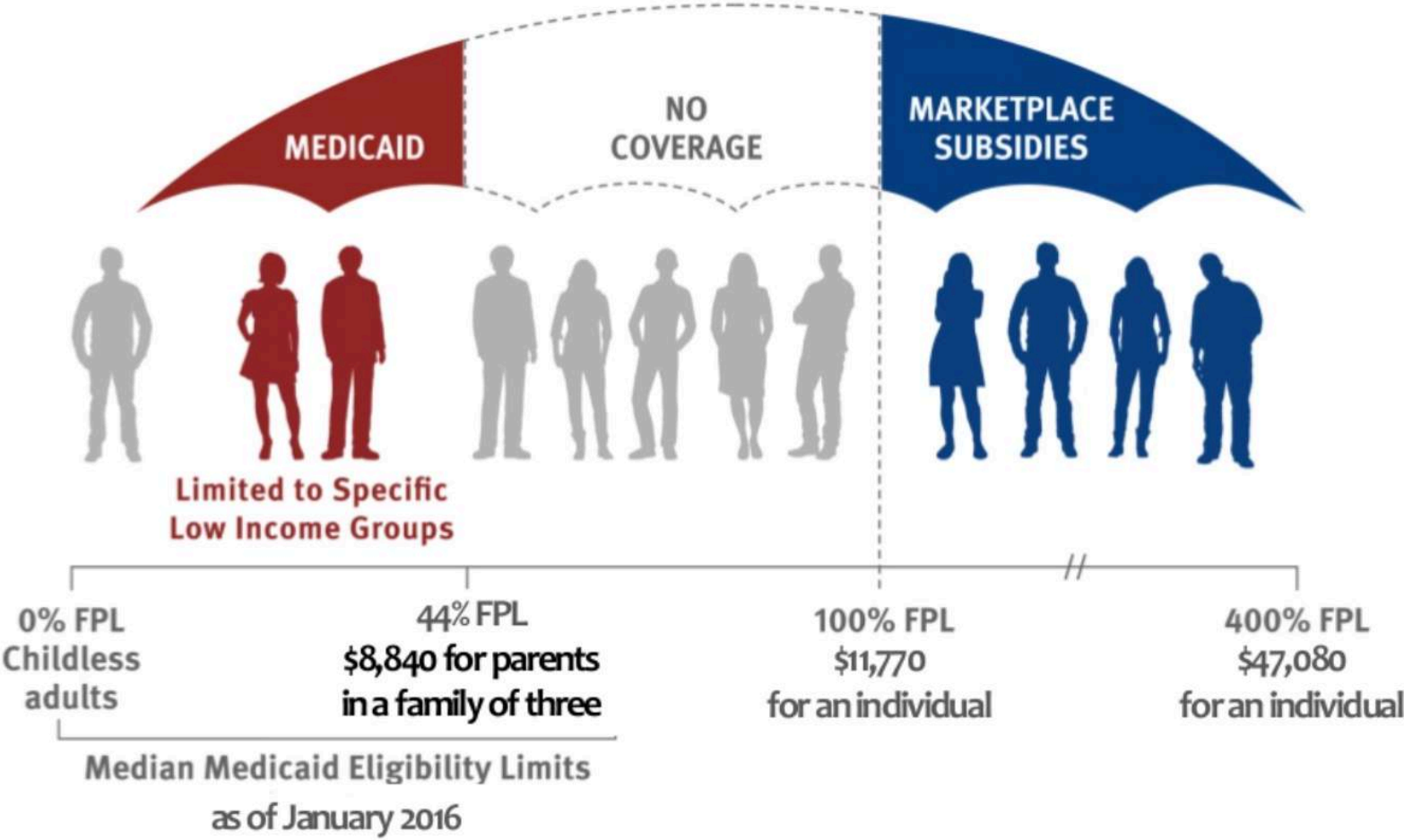
Who qualifies for Medicaid and therefore are not in The Gap?

- Complex, but in general, in NC Medicaid covers those who are very poor and are:
 - Pregnant – but only if income is < 201% of the federal poverty level (FPL)
 - Children (including CHIP)
 - Parents – only if income is < 44% of FPL
 - Disabled – if <100% FPL
 - Elderly nursing home care – if < 100% FPL

So, again, who is in The Gap?

- Childless adults with income < 100% FPL
- Parents with income 44% – 100% FPL

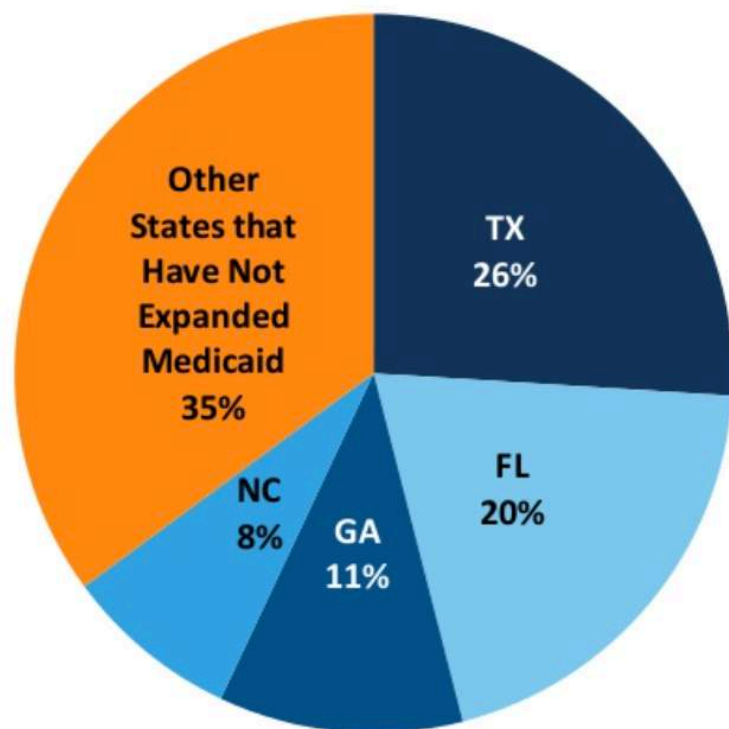
In states that have not adopted the Medicaid expansion, poor adults fall into a coverage gap, earning too much to qualify for Medicaid but too little for subsidies for Marketplace coverage.



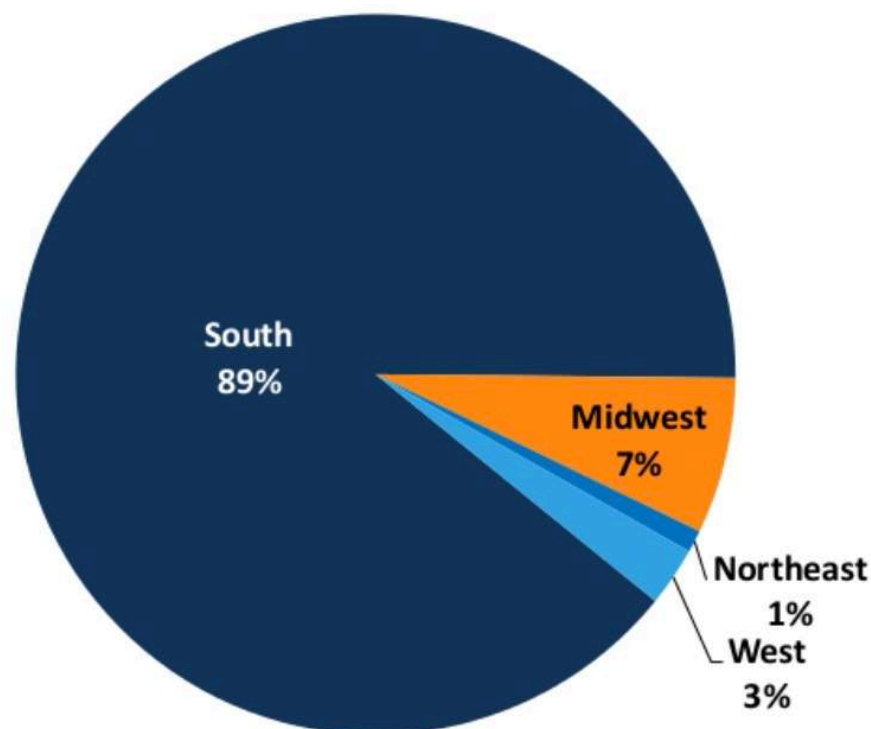
What types of people are in
The Gap?

An estimated 2.9 million nonelderly adults fall into the coverage gap, most of whom reside in the South.

Distribution By State:



Distribution By Geographic Region:

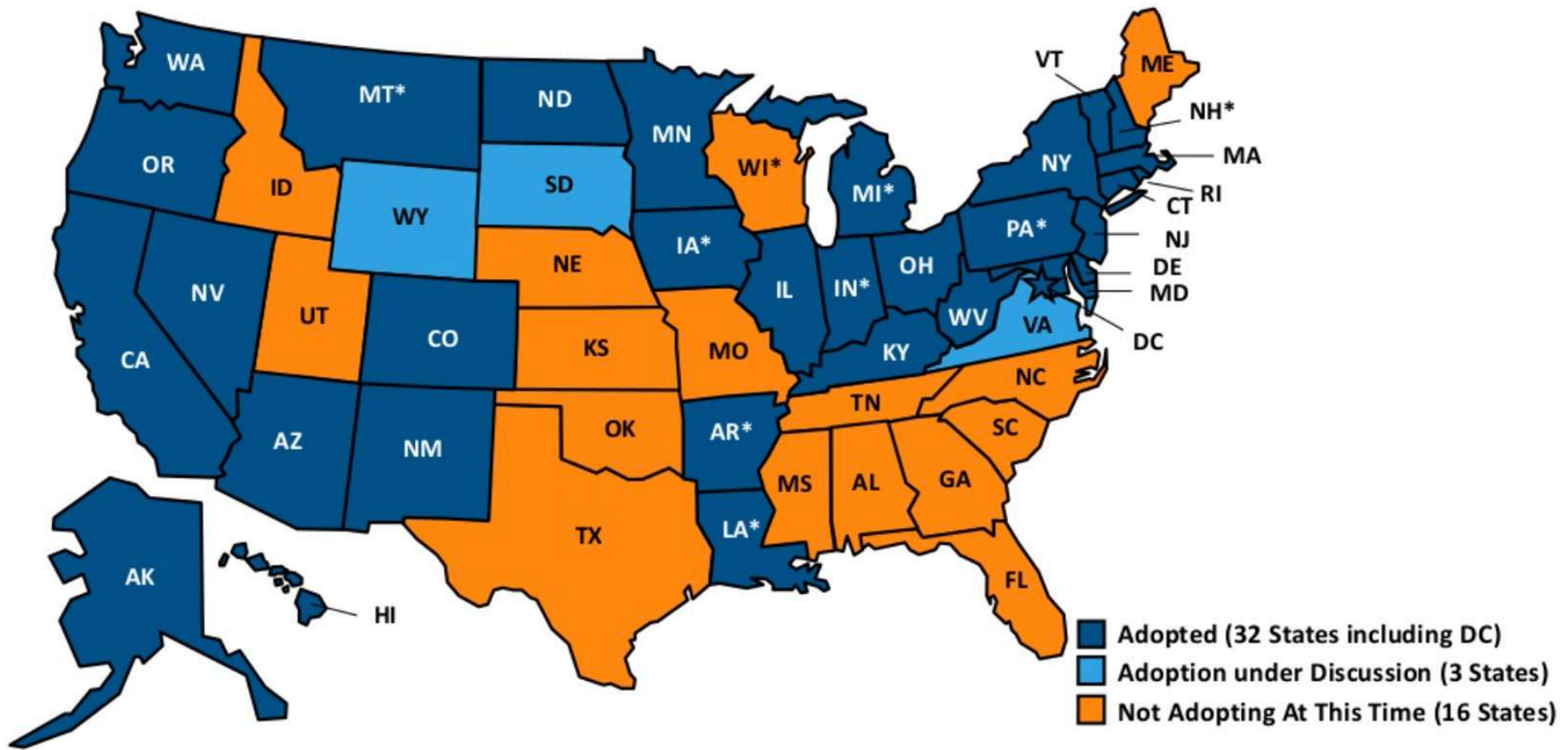


Total = 2.9 Million in the Coverage Gap

Note: Totals may not sum to 100% due to rounding.

Source: Kaiser Family Foundation analysis based on 2015 Medicaid eligibility levels updated to reflect state Medicaid expansion decisions as of January 2016 and 2015 Current Population Survey data.

Status of Medicaid Expansion Decisions, January 12, 2016



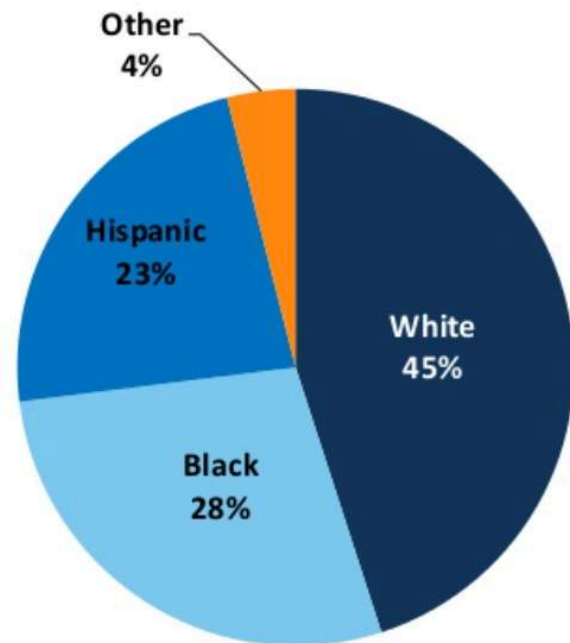
NOTES: Current status for each state is based on KCMU tracking and analysis of state executive activity. *AR, IA, IN, MI, MT, NH and PA have approved Section 1115 waivers. Coverage under the PA waiver went into effect 1/1/15, but it has transitioned coverage to a state plan amendment. Coverage under the MT waiver went into effect 1/1/16. LA's Governor signed an Executive Order to adopt the Medicaid expansion on 1/12/16, but coverage under the expansion is not yet in effect. WI covers adults up to 100% FPL in Medicaid, but did not adopt the ACA expansion.

SOURCE: "Status of State Action on the Medicaid Expansion Decision," KFF State Health Facts, updated January 12, 2016.

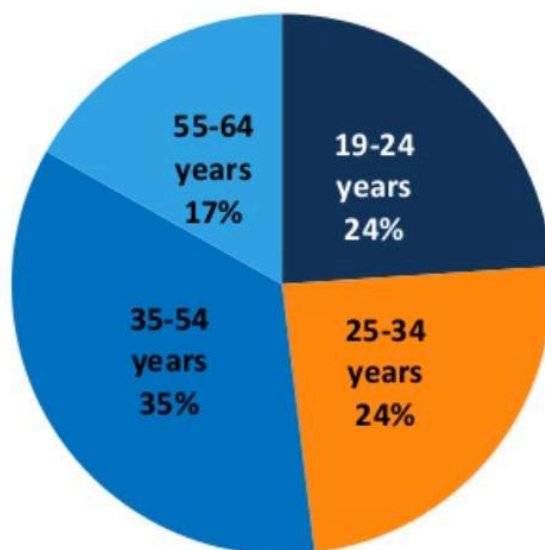
<http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>

More than half of adults in the coverage gap are adults of color. Adults in the coverage gap are of varying age and health status.

*Distribution By
Race/Ethnicity:*



*Distribution By
Age:*



*Distribution By
Health Status:*



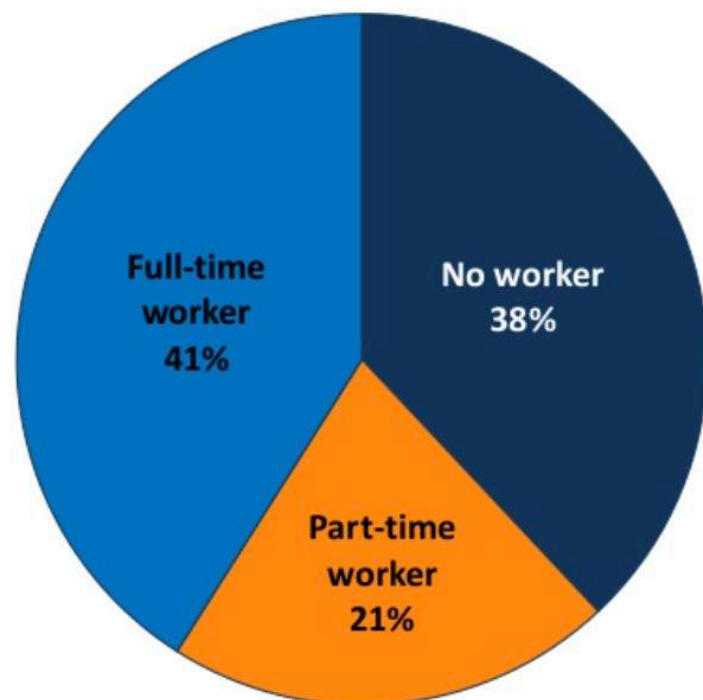
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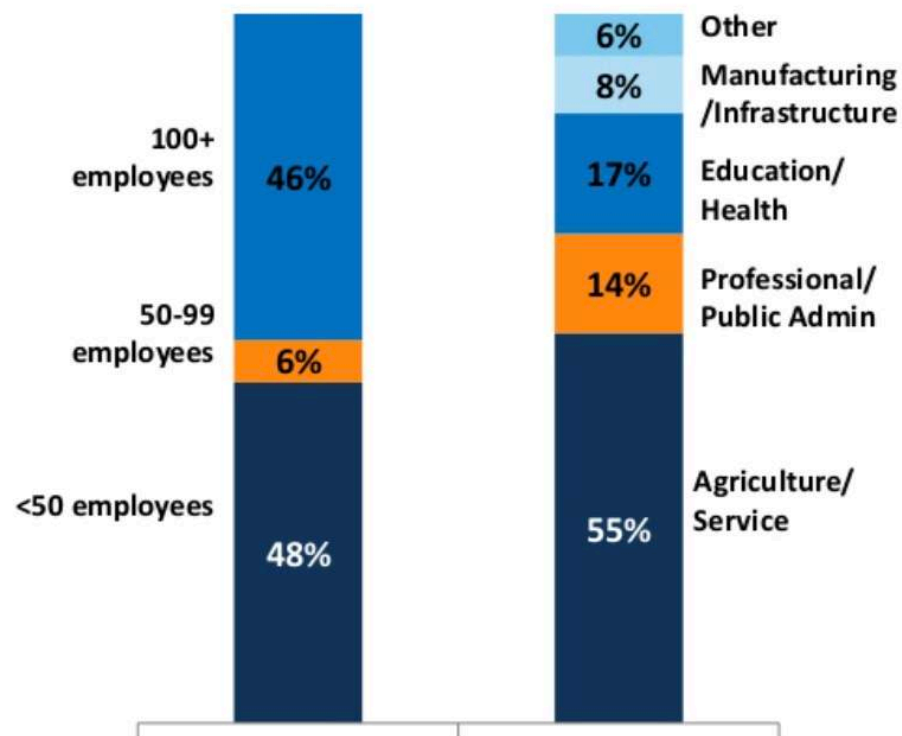
Nearly two-thirds of adults in the coverage gap are in a family with a worker, but most work in jobs that are unlikely to offer insurance.

Family work status :



Total = 2.9 Million in the Coverage Gap

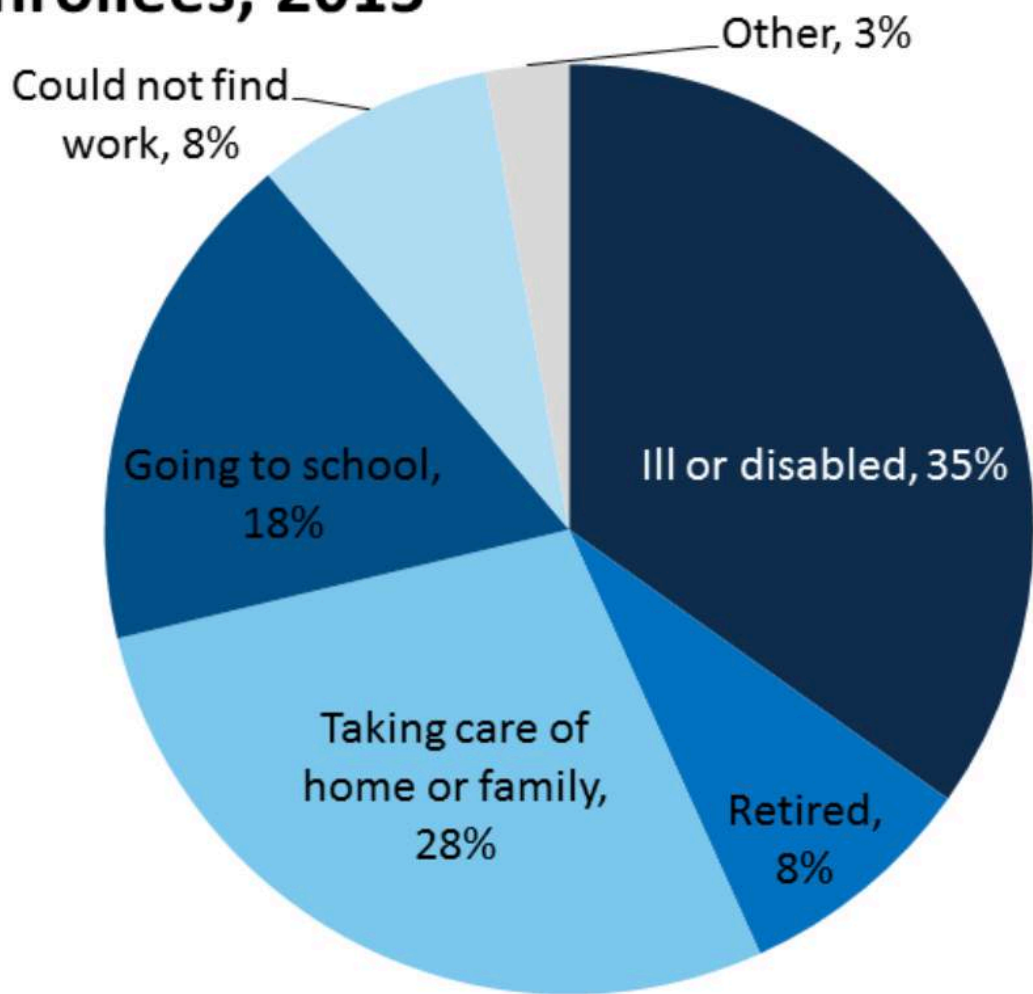
Firm size and industry among those working:



Total = 1.5 Million Workers in the Coverage Gap

Notes: Industry classifications: Agriculture/Service includes agriculture, construction, leisure and hospitality services, wholesale and retail trade. Education/Health includes education and health services. Professional/Public Admin includes finance, professional and business services, information, and public administration. Manufacturing/Infrastructure includes mining, manufacturing, utilities, and transportation. Totals may not sum to 100% due to rounding.
Source: Kaiser Family Foundation analysis based on 2015 Medicaid eligibility levels updated to reflect state Medicaid expansion decisions as of January 2016 and 2015 Current Population Survey data.

Main reasons for not working among non-SSI, adult Medicaid enrollees, 2015



Total = 9.8 Million

NOTE: Includes nonelderly adults who do not receive Supplemental Security Income (SSI).
SOURCE: Kaiser Family Foundation analysis of March 2016 Current Population Survey.

Health Affairs Blog, March 6, 2017:

Only 13% of adults covered by Medicaid's expansion are able-bodied and not working, in school or seeking work. Of that small group, three quarters report that they are not working in order to care for family members and the rest report other reasons, like being laid off. A much higher share of overall American adults are unemployed or not in the labor force, according to 2015 census data.

Medicaid expansion enrollees are more likely to be working or looking for work than the general public.

Why are we now focusing on the Opioid Crisis?

- 2013-2016 NC LWV advocated to “Close the Gap,” sure that pointing out the obvious economic windfall would quickly convert the unbelievers. Were we ever naïve!
- 11/8/2016: stunned, stopped, almost gave up
- 3/2017: Met with NC DHHS, who urged us to bring new urgency to our advocacy, because **the opioid epidemic is an emergency that needs an immediate solution, and health care coverage is an indispensable part of that solution.**

The Opioid Crisis

A “Perfect Storm” of Seven Things

1. Sharply increased emphasis on pain treatment
2. New semi-synthetic narcotics (Vicodin, Oxycontin, etc) thought to be more potent and less addictive
3. Aggressive marketing by the manufacturers
4. 2000's: Loss of manufacturing jobs and small farms
5. 2007: Great Recession, slow recovery with persistent unemployment, worse jobs, poor future
6. Anger, depression, hopelessness, despair
7. Opportunity: Rx drugs, cheap heroin and fentanyl

How Bad is the Opioid Epidemic?

Daily opioid-related deaths in NC:

1999 = 0.3/day

2002 = 0.9

2005 = 1.5

2010 = 1.7

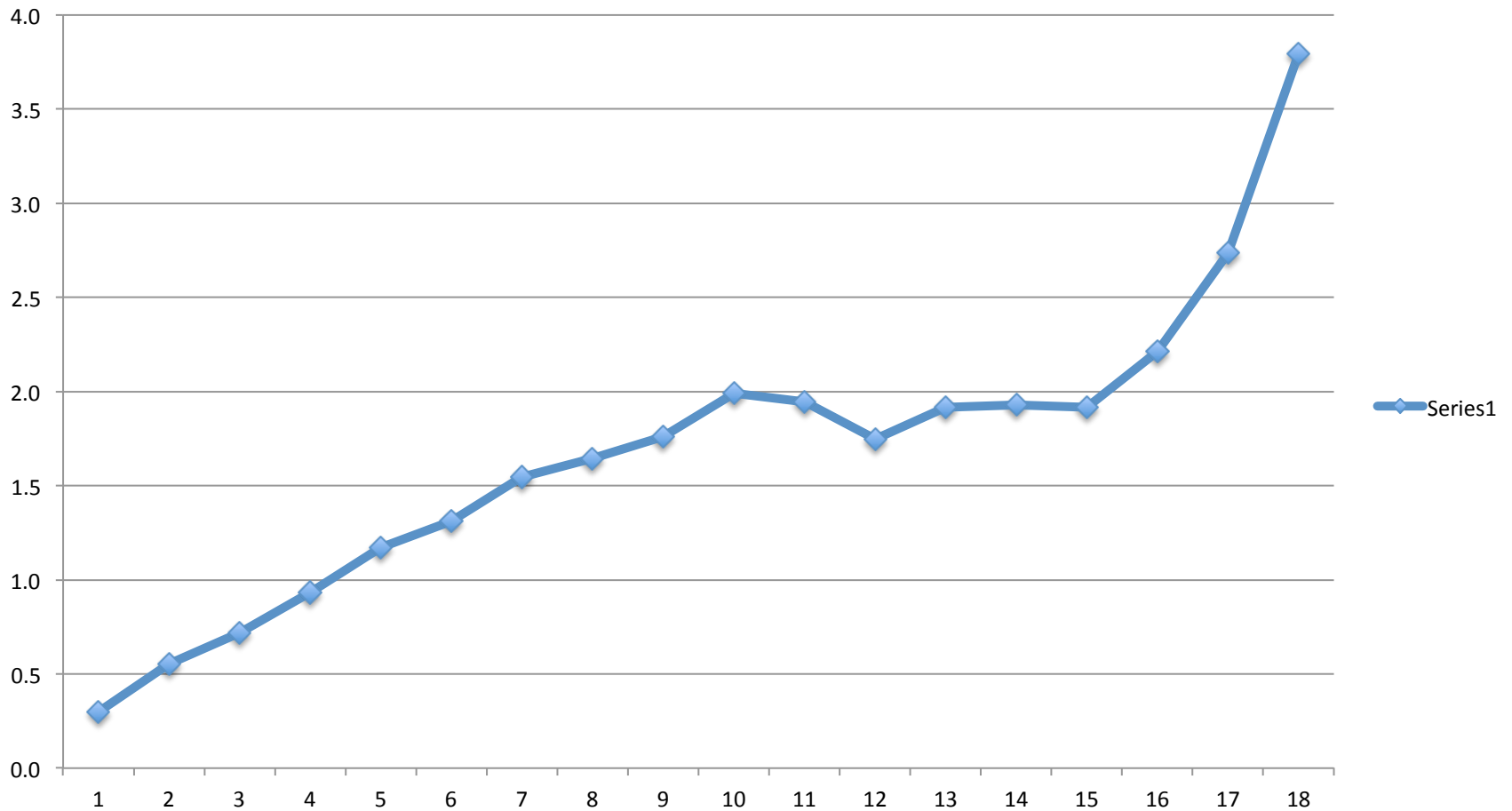
2013 = 1.9

2014 = 2.2

2015 = 2.7

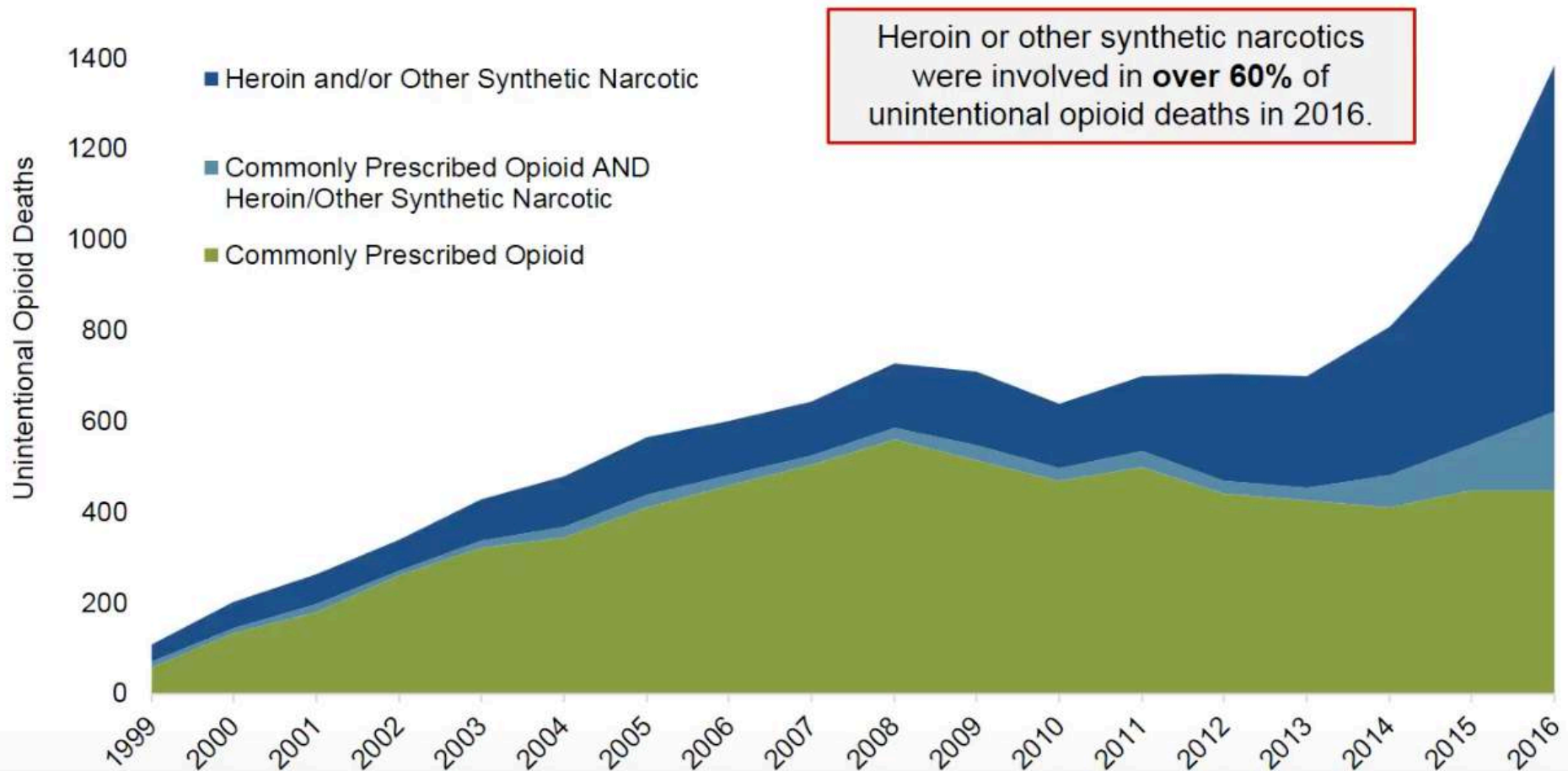
2016 = 3.7

Daily Opioid Deaths in NC, 1999-2016



Unintentional Opioid Overdose Deaths by Opioid Type

North Carolina Residents, 1999-2016



Source: N.C. State Center for Health Statistics, Vital Statistics-Deaths, 1999-2016

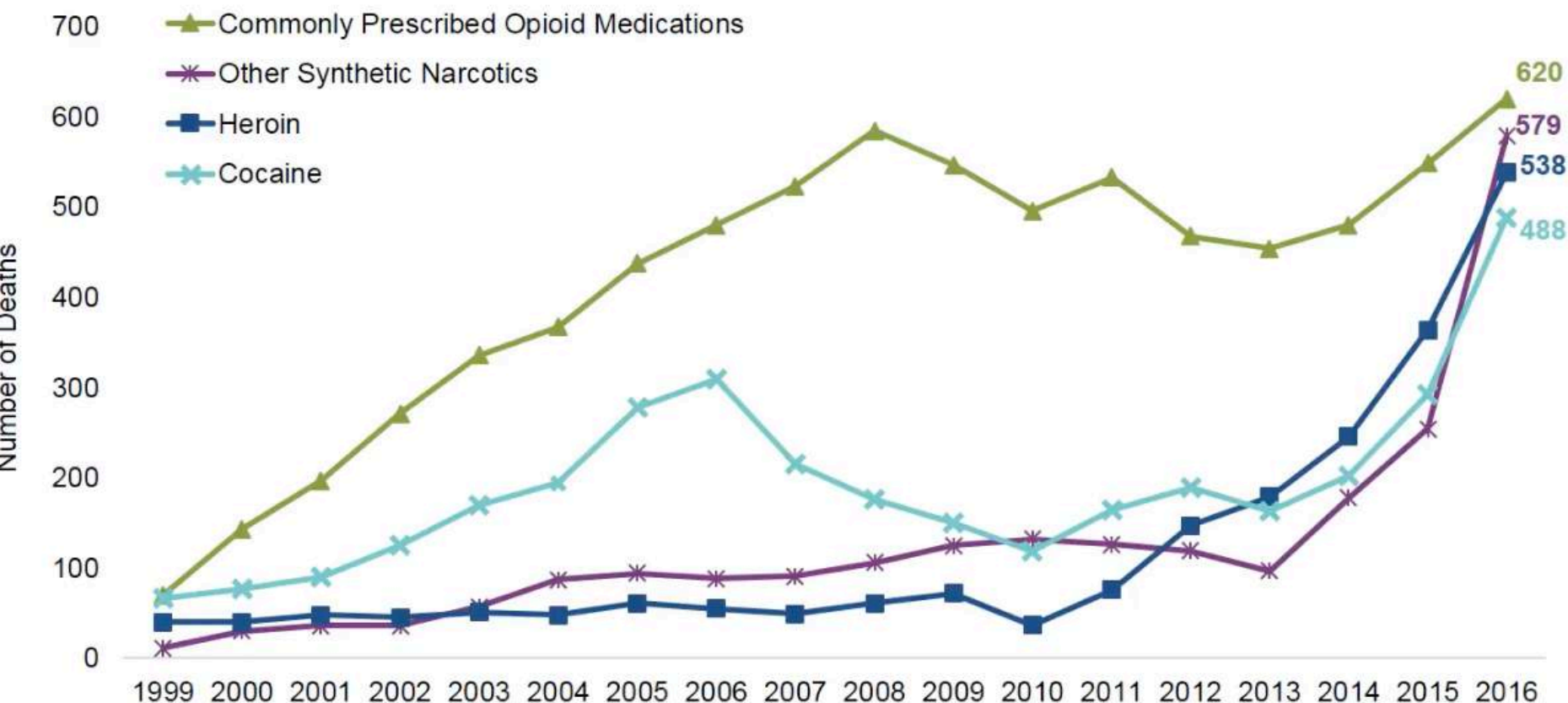
Unintentional medication/drug (X40-X44) with specific T-codes by drug type, Commonly Prescribed Opioid

Medications=T40.2 or T40.3; Heroin and/or Other Synthetic Narcotics=T40.1 or T40.4

Analysis by Injury Epidemiology and Surveillance Unit

North Carolina
Injury & Violence
PREVENTION Branch

Substances* Contributing to Unintentional Medication and Drug Overdose Deaths, North Carolina Residents, 1999-2016



*These counts are not mutually exclusive. If the death involved multiple drugs it can be counted on multiple lines.

Source: N.C. State Center for Health Statistics, Vital Statistics-Deaths, 1999-2016,
 Unintentional medication or drug overdose: X40-X44 with any mention of specific T-codes by drug type.
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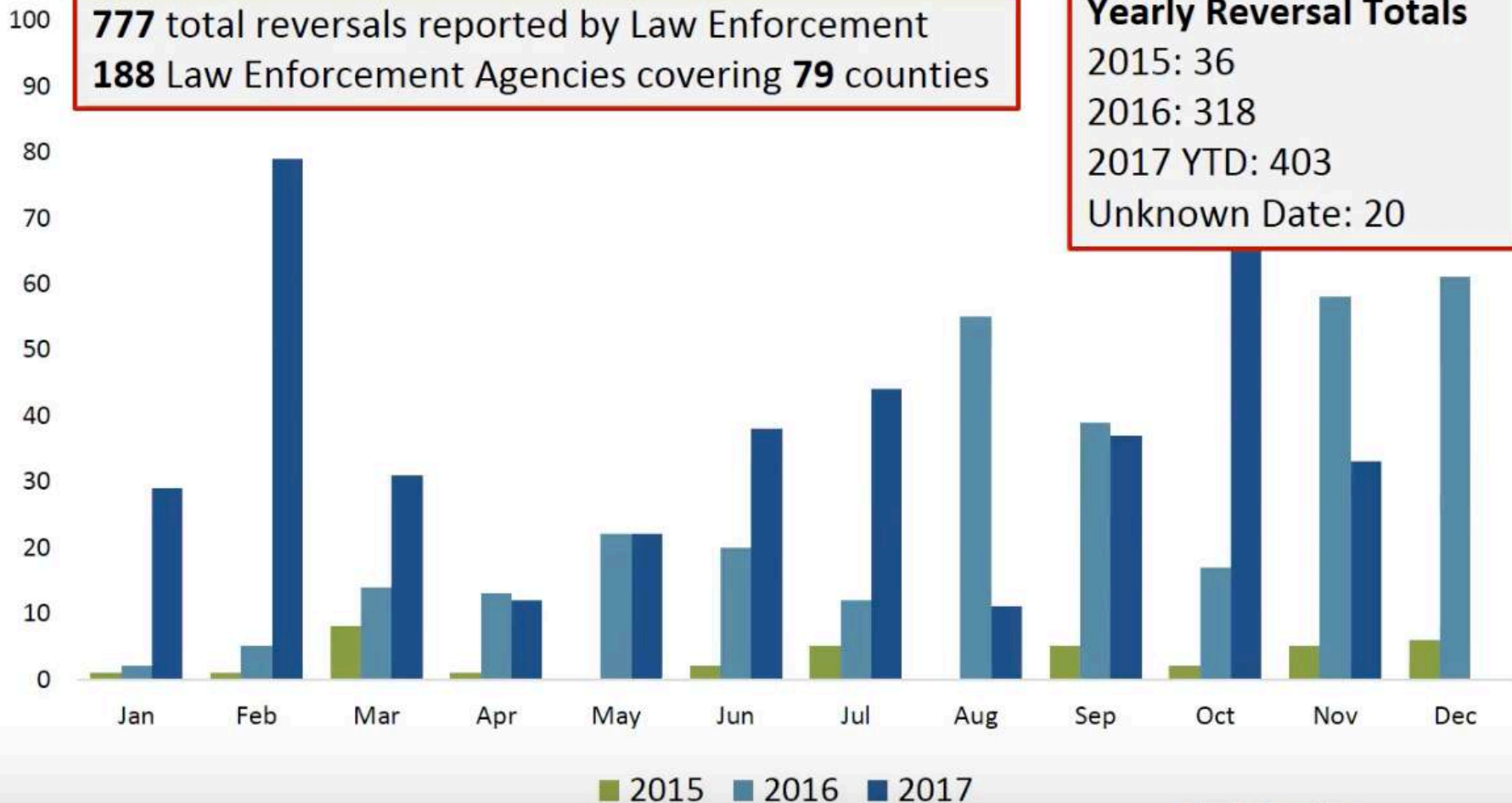
OF NORTH CAROLINA

Opioid Overdose Reversals with Naloxone Reported by NC Law Enforcement Agencies, 1/1/2015-9/30/2017

777 total reversals reported by Law Enforcement
188 Law Enforcement Agencies covering **79** counties

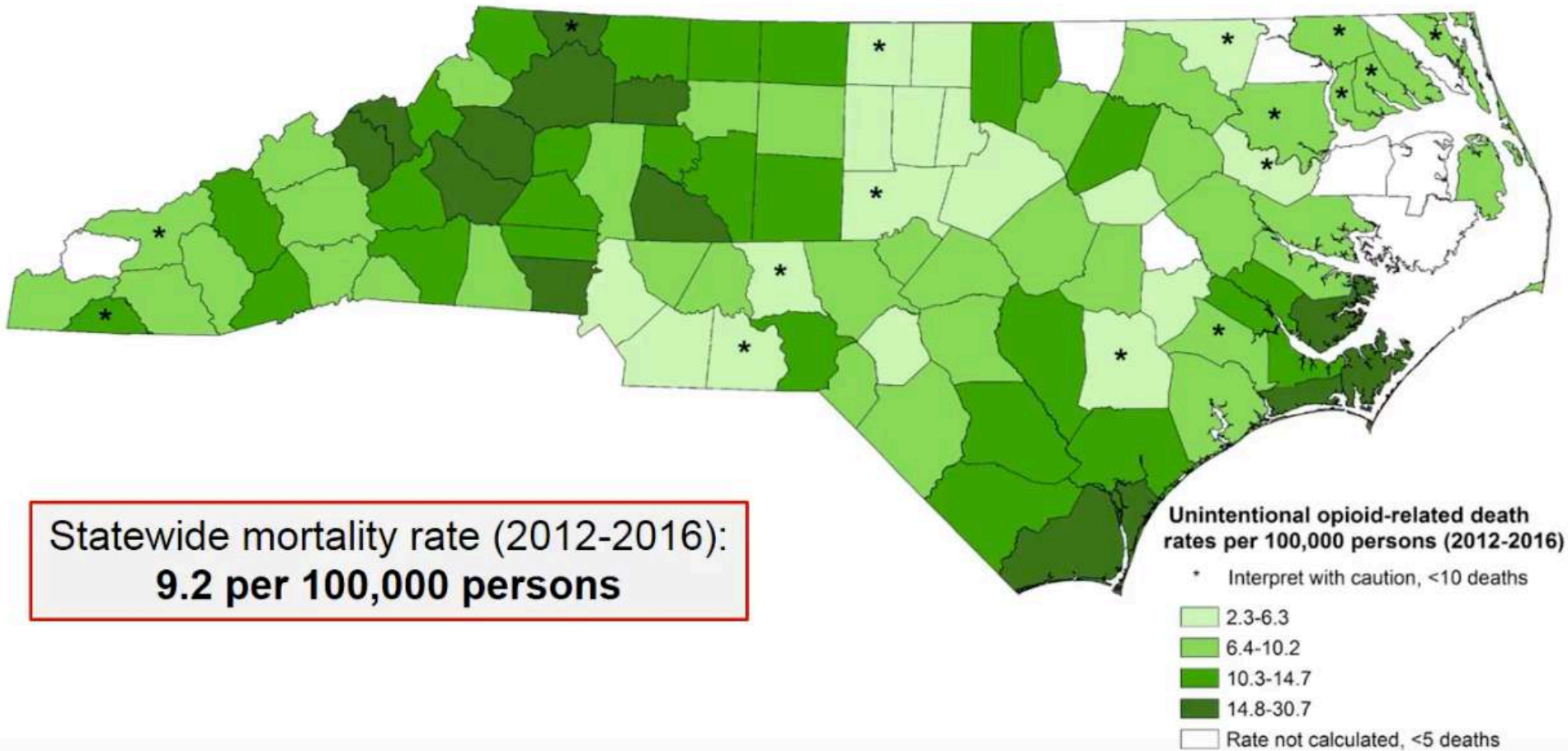
Yearly Reversal Totals
2015: 36
2016: 318
2017 YTD: 403
Unknown Date: 20

Number of Reversals Reported



Unintentional Opioid-related Death Rates by County

per 100,000 North Carolina Residents, 2012-2016

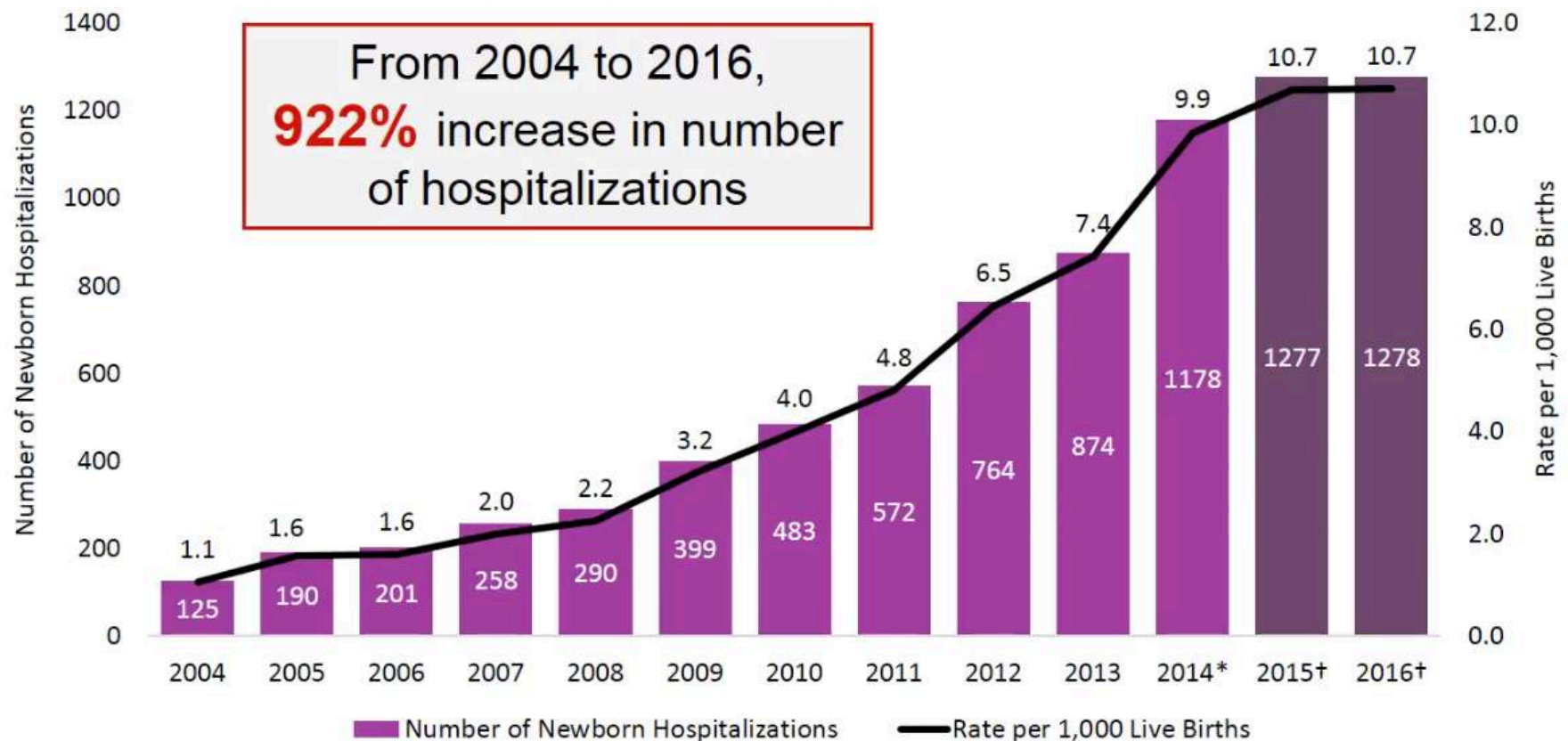


Source: Deaths-N.C. State Center for Health Statistics, Vital Statistics, 2012-2016,
Any mention of T40.0 (opium), T40.2 (Other Opioids), T40.3 (Methadone) and/or T40.4 (Other synthetic opioid) and
unintentional intent (X40-X44)/Population National Center for Health Statistics, 2012-2016
Analysis by Injury Epidemiology and Surveillance Unit

North Carolina
Injury & Violence
PREVENTION Branch

LEAGUE OF WOMEN VOTERS
OF NORTH CAROLINA

Number & Rate of Hospitalizations Associated with Drug Withdrawal in Newborns, North Carolina Residents, 2004-2016



*2014 data structure changed to include up to 95 diagnosis codes. Impact on surveillance unclear.

†2015 ICD 9 CM coding system transitioned to ICD10 CM. Impact on surveillance unclear.

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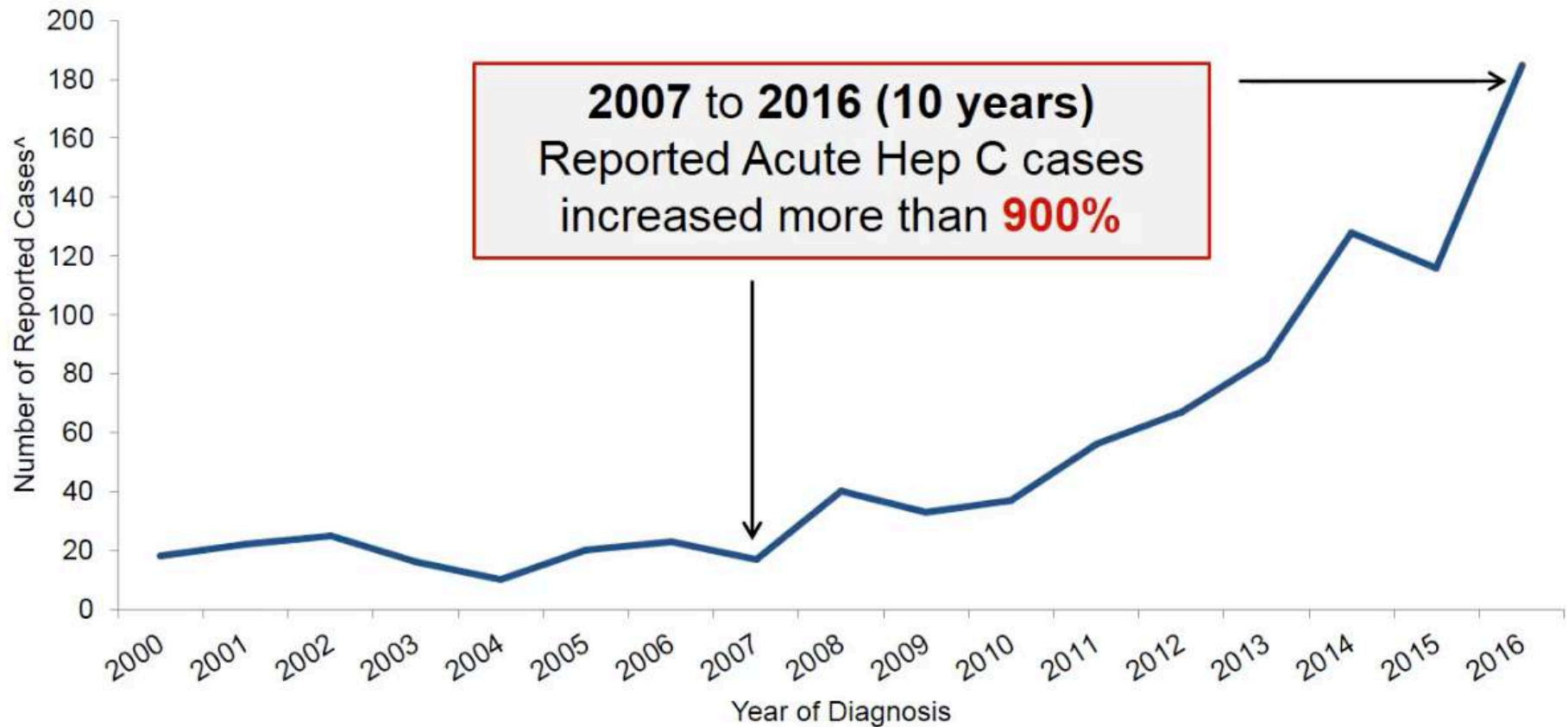
Source: N.C. State Center for Health Statistics, Hospital Discharge Dataset, 2004-2016 and Birth Certificate records, 2004-2016

Analysis by Injury Epidemiology and Surveillance Unit

LEAGUE OF WOMEN VOTERS
OF NORTH CAROLINA

Increase in Acute Hepatitis C Cases[^]

North Carolina, 2000–2016



Note: Case definition for acute Hepatitis C changed in 2016.

[^] Estimated true number 10–15x higher than number of reported cases

Source: NC Electronic Disease Surveillance System, 2000–2016

Analysis by NC DPH Epidemiology Section, Communicable Disease Branch

North Carolina
Injury & Violence
PREVENTION Branch

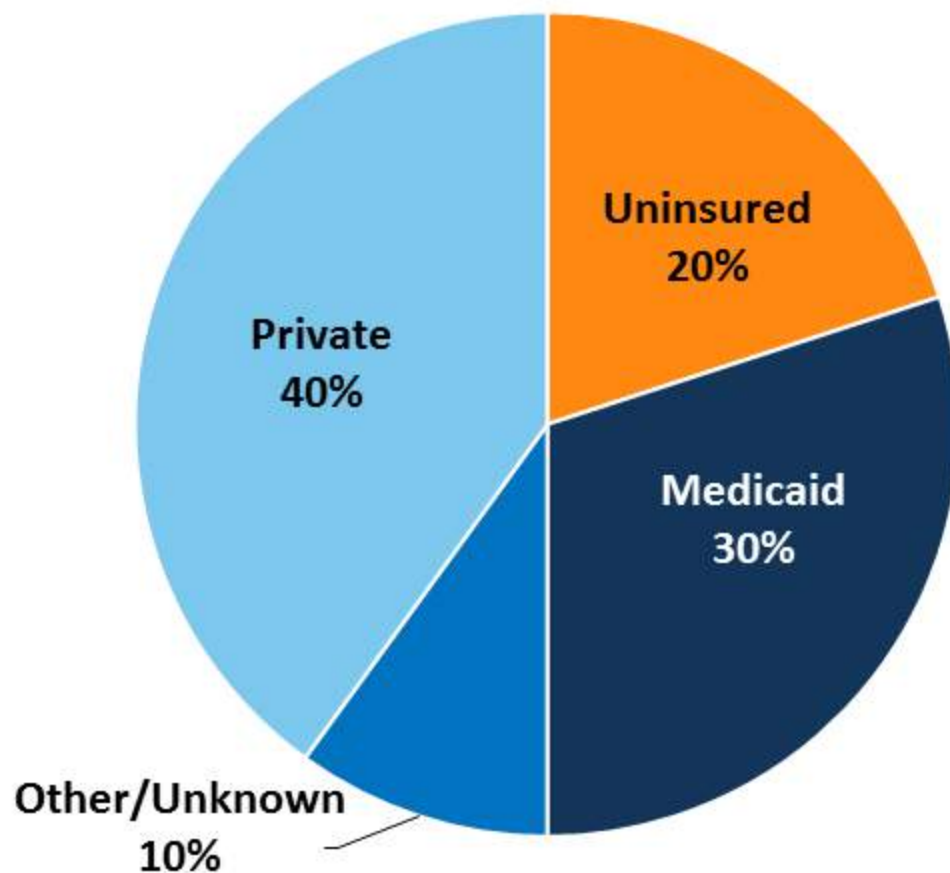
Other Reasons This Is a Crisis

- **Use of heroin, fentanyl and super-potent fentanyl analogs are skyrocketing**, and starting to replace prescription opioids as first-use drugs
- And **cocaine** and purified **methamphetamine** are making a huge comeback!
- Our **jails, criminal justice system and foster care** are overwhelmed
- **Employers can't find enough workers** without a positive drug test or without a drug-related felony
- All of this **costs NC \$1.3 Billion per year**, according to the CDC

Characteristics of People with Opioid Use Disorder

Figure 1

Insurance Status of Adults with Opioid Addiction



Total: 2.2 million people

SOURCE: Kaiser Family Foundation analysis of the 2015 National Survey of Drug Use and Health (NSDUH)

Mental Illness Among Uninsured Adults with Opioid Addiction (kff)

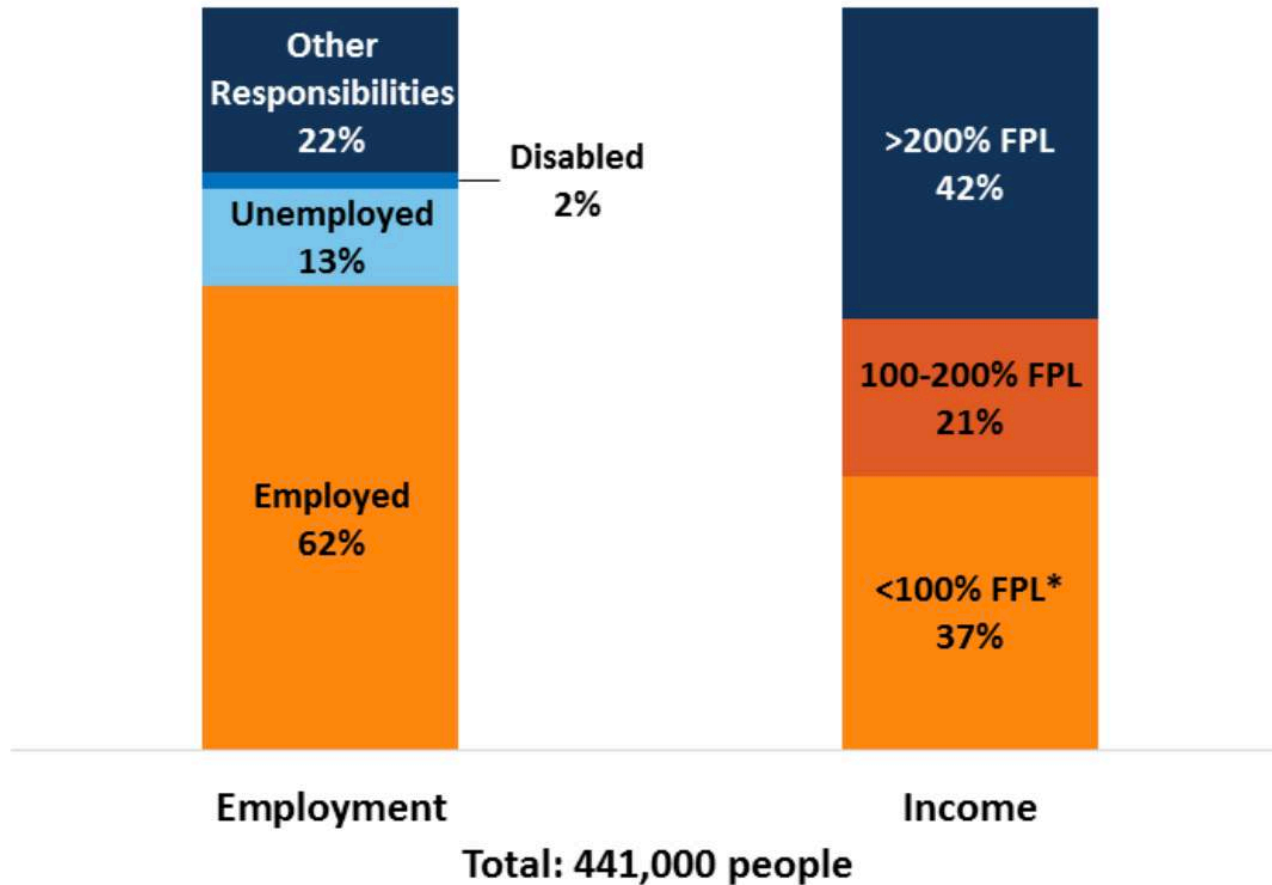
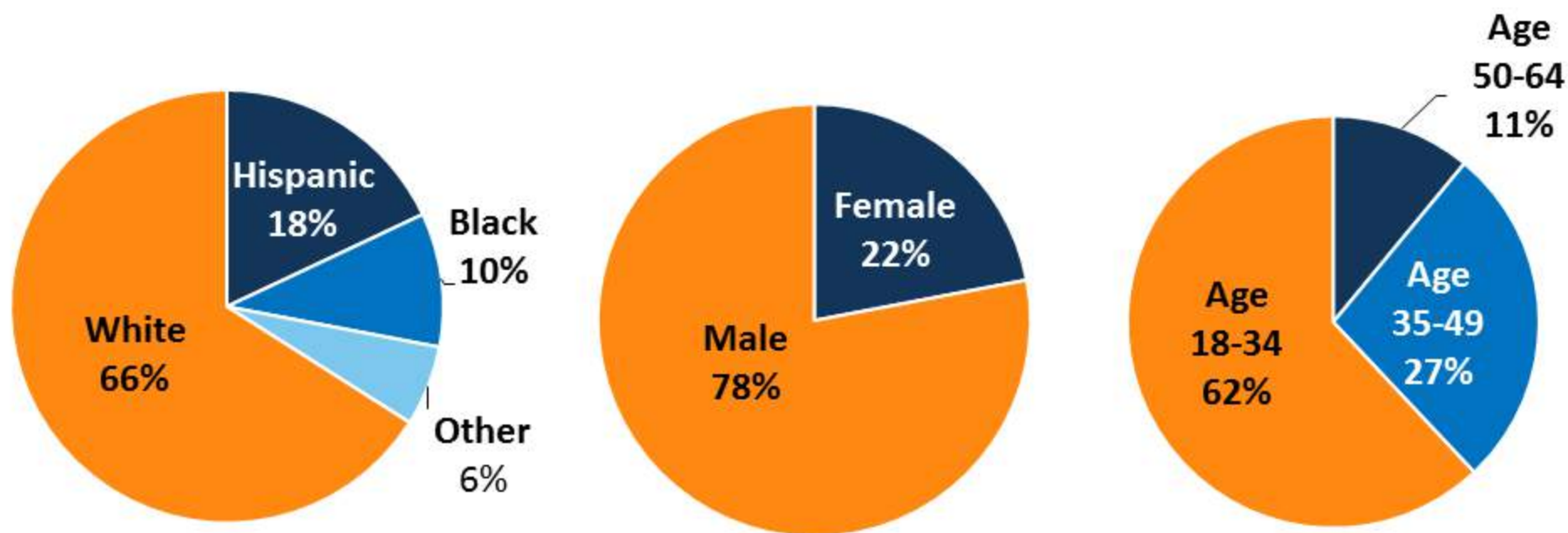


Figure 2

Race, Gender, and Age of Uninsured Adults with Opioid Addiction

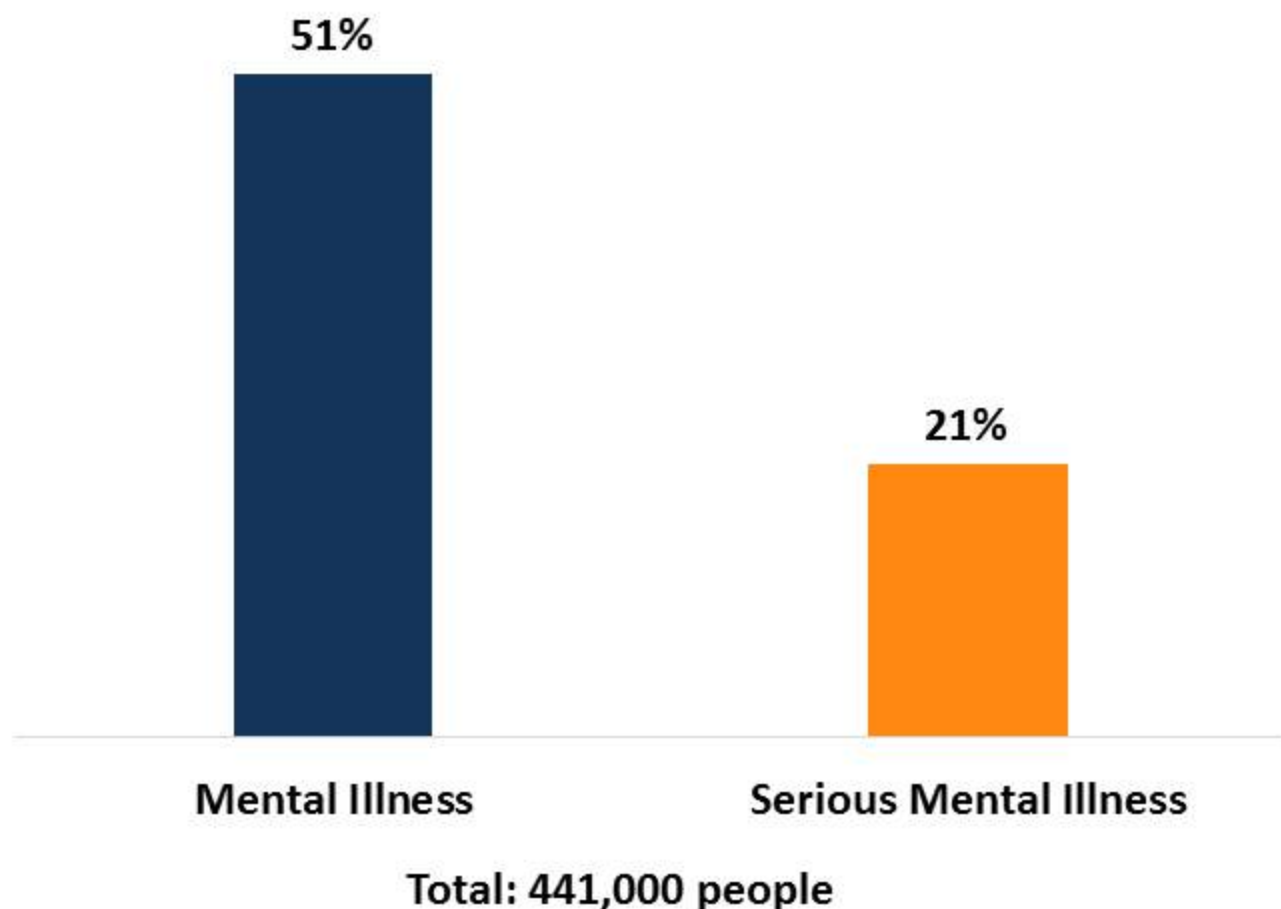


Total: 441,000 people

SOURCE: Kaiser Family Foundation analysis of the 2015 National Survey of Drug Use and Health (NSDUH)

Figure 5

Mental Illness Among Uninsured Adults with Opioid Addiction



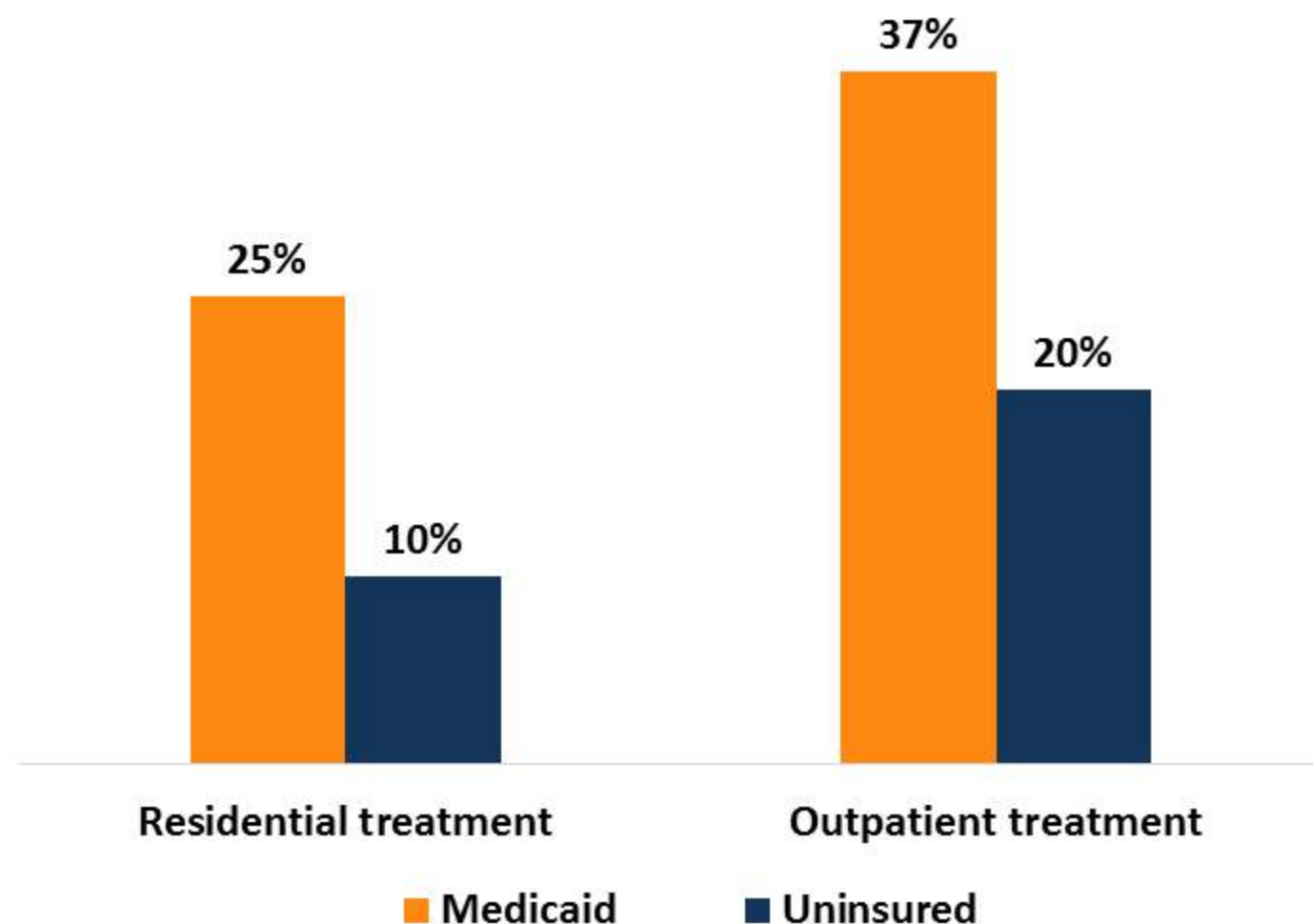
SOURCE: Kaiser Family Foundation analysis of the 2015 National Survey of Drug Use and Health (NSDUH)

What happens when people are uninsured and can't pay?

- Many people with OUD decline EMS transport and have given up applying for voluntary hospitalization and treatment because they cannot pay for it
- People wait for days in EDs while social service looks for beds and a way to pay for treatment
- When released from acute rehab, uninsured people can't pay for MAT, so they have to immediately find a fix, leading to relapse

Figure 6

Treatment Among Adults with Opioid Addiction



Total: 1.1 million people

SOURCE: Kaiser Family Foundation analysis of the 2015 National Survey of Drug Use and Health (NSDUH)

How can NC assure that persons with OUD have access to the acute and long-term treatment that they need?

- **Provide health care coverage to low income people who are in The Coverage Gap – this is an essential part of solving the opioid crisis.**
- Make available private insurance without high deductibles, co-pays and co-insurance – if a policy has these, people are effectively uninsured
- Enforce the PARITY Act, which mandates equal coverage for mental/behavioral and physical health conditions

How can NC assure that persons with OUD have access to the acute and long-term treatment that they need?

Obtain a waiver from the IMD Exclusion

- The 1965 Medicaid Act prohibited Medicaid financing for more than 16 “mental disorder” beds per institution
- NC has an IMD waiver pending

Increase the number of mental health professionals

De-stigmatize substance use disorder (SUD)

- Addiction is a chronic disease, not a moral defect
- Criminalization and incarceration do not work and are more expensive than treatment
- Persons with SUD need continuous long-term treatment, perhaps life-long, including robust social support

But what about special state and federal funding for the opioid crisis?

- The funds are always inadequate for the job
- Short-term funding won't work – people with SUD will relapse when funds run out
- Funding that is required over a period of years has to be protected from the political cycle
 - Only a major long term program can assure this (almost!).

Carolina Cares (HB 662)

A Possible Starting Point for Health Coverage Legislation in NC

- Purpose: To bring health care coverage to low income citizens of North Carolina
- Eligibility: Income less than 133% FPL
- Benefits: Similar to current Medicaid
- Participant contributions:
 - Premiums of 2% of income (\$241/yr for single adult at FPL)
 - Exceptions:
 - income < 50% FPL
 - medical or financial hardship

Carolina Cares (HB 662)

Requirements

- Co-payments: similar to current Medicaid
- Preventive Care and Wellness activities such as physicals, mammograms, colonoscopies, weight management

Carolina Cares (HB 662)

- Work requirements (“employed or engaged in activities to promote employment”)
- Exemptions:
 - Caring for a dependent minor child, an adult disabled child, or a disabled parent.
 - In active treatment of substance abuse
 - Determined to be medically frail

Carolina Cares (HB 662)

Funding limited to:

Federal funds at “the highest federal financial participation percentage available,” with the program stopped if the funds ever drops below this percentage

Premiums

Health care-related assessments, including hospital assessments. No other State funds may be used.