Uninsurance in North Carolina: Progress and Opportunities

Erica Palmer Smith, Kathryn Horneffer, Peg O'Connell

Virtually all of the Healthy North Carolina 2030 goals rely on access to affordable health care. This commentary provides an overview of how North Carolina's coverage gap impacts the state's health status and how expanding Medicaid could improve the odds of reaching Healthy NC 2030 goals.

Introduction

One of the goals of the Healthy North Carolina 2030 project is to improve access to affordable health insurance. Many of the Healthy North Carolina 2030 goals—including reduced infant mortality, increased economic security, and access to mental health care—are closely tied to insurance status, and many become more achievable with increased access to health insurance [1]. Because of the connection between health status, affordable health care, and health insurance, it is imperative that we find a solution for those who are uninsured and stuck in the coverage gap. This commentary provides an overview of how North Carolina's coverage gap impacts health status and how expanding Medicaid could improve the odds of reaching the Healthy NC 2030 goals.

Overview of Uninsurance in North Carolina

Mirroring national trends, North Carolina's uninsurance rate dropped dramatically following the passage of the Affordable Care Act (ACA) in 2010 [2]. However, as in most states that have not expanded Medicaid, uninsurance levels remain higher than national levels [2]. In 2019 (two years after the publication of the Healthy NC 2030 report), 11.4% of all North Carolinians were uninsured, compared to 9.2% nationally [3]. Among nonelderly adults—those under age 65 who do not qualify for Medicare—16.4% were uninsured in 2019, much higher than the national rate of 12.9% [4].

Policy changes under the prior federal administration caused uninsurance rates to rise nationally between 2018 and 2019. In North Carolina, the uninsured population grew 6% during that time period, and the uninsured rate for children grew 9% [2]. Job loss and economic devastation from the pandemic caused the rate to climb even further in 2020. NC Medicaid estimates that nearly 20% of the nonelderly adult population lacked health coverage at the end of 2020 [3].

Understanding the Health Insurance Coverage Gap

Under the ACA, states had the option to expand Medicaid eligibility to all individuals who made up to 138% of the federal poverty level (FPL). North Carolina, however, is one of 12 states that did not expand. In order to qualify for Medicaid in North Carolina, one must have an income level under a specified limit and qualify under one of the following categories: a child, a parent of a dependent child, pregnant, blind, disabled, or aged 65+ years. Income limits depend on the eligibility category; for example, adults with dependent children can make no more than 42% FPL to qualify, whereas children under six years old must fall under 210% FPL [3].

A person is in the "health insurance coverage gap" if they do not qualify for Medicaid but do not make enough money to qualify for subsidies in the insurance marketplace, which begin at 100% FPL. People in the coverage gap do not have access to affordable health insurance. Before the pandemic, it was estimated that between 372,000 and 401,000 uninsured nonelderly adults would gain insurance coverage if North Carolina closed its coverage gap [5, 6]. The number of people in the coverage gap has grown during the pandemic. Some researchers now estimate as many as 682,000 adults would benefit from Medicaid expansion in North Carolina [6].

Among those who would gain coverage if the state closed its gap, over half are under age 40, and a third are parents of children under 18 [3]. Of the 76% who are employed, 16% work in accommodation and food services, 15% work in retail, 11% in construction, 10% in administrative and waste management services, and 10% in manufacturing [3, 7]. Fifty-nine percent of workers in the coverage gap are white, 32% are Black, and 6% are Latino [7]. Rural counties have higher proportions of both uninsured low-income nonelderly adults and uninsured workers [3, 7].

The Benefits of Expanding Insurance Access

Over time, the case for expanding Medicaid has grown stronger. Because 38 states and the District of Columbia

Electronically published May 2, 2022.

Address correspondence to Erica Palmer Smith, 3131 RDU Center Dr, STE 100, Morrisville, NC 27560 (erica@care4carolina.com).

N C Med J. 2022;83(3):169-172. 0029-2559/2022/83308

have expanded Medicaid, there is a large body of evidence documenting the benefits of Medicaid expansion and insurance coverage to public health, public safety, and the local economy.

Public Health and Health System

There are proven health benefits associated with access to affordable health insurance coverage. Nationwide, closing the coverage gap has been associated with at least 19,000 prevented deaths [8]. When people have access to coverage, they are more likely to seek preventive care and less likely to delay needed care. This improves outcomes for conditions that benefit from early diagnosis and disease management [9]. For example, death rates for early-stage breast cancer patients are 31% higher in states with limited Medicaid eligibility [10]. Additionally, counties in expansion states saw 4.3 fewer annual cardiovascular deaths per 100,000 population compared to counties in non-expansion states [11].

Insurance coverage has also been associated with improved maternal and infant health outcomes, likely because it improves preconception and early prenatal health and reduces insurance churn after birth [12]. States that expanded Medicaid save as many as seven maternal lives per 100,000 births and see a 50% greater decline in infant mortality [12, 13].

Finally, expansion has been linked to improved mental health outcomes—as well as a 6% decrease in deaths from opioid overdose [9, 14].

Expansion also strengthens health care infrastructure. Uninsured people may wait to seek care until it is an emergency, leading to high bills that they cannot pay. Hospitals often write off these bills as charity care or bad debt, never getting reimbursed for their services. When hospitals serve a large number of uninsured patients, they may be at increased financial risk; this is a particular challenge for rural hospitals. Eleven rural hospitals in North Carolina have closed since 2005, and there are currently six rural hospitals considered to be at high financial risk [3, 15]. By reducing the number of uninsured patients, Medicaid expansion boosts hospital finances. In states that have already closed their gap, the likelihood of rural hospital closure decreased by 62% [16].

Expansion also increases the number of providers accepting Medicaid, increasing provider capacity. In expansion states, appointment availability for Medicaid beneficiaries increased by 5.4 percentage points, and wait times decreased by 6.7 percentage points [17]. In Michigan, the availability of primary care appointments for Medicaid beneficiaries increased by 12% after the state closed its gap [18].

Incarceration and Public Safety

Closing the insurance gap also decreases incarceration and improves public safety. Many incarcerated individuals struggle with substance use and mental health issues. About 70% of incarcerated individuals have a substance use disorder, and 65% report symptoms of mental illness [19]. Access to health insurance can help individuals manage their behavioral health, leading to reductions in crime and incarceration. Indeed, closing the coverage gap has been linked to a 5.3% reduction in violent crime, and the rate of drug arrests was as much as 41% lower in counties in expansion states [20, 21].

Similarly, access to insurance can decrease recidivism. Unfortunately, only about 2% of incarcerated individuals in North Carolina are covered by Medicaid when they exit prison [19]. Without access to treatment for substance use and mental health problems, the individual has a higher chance of being re-arrested. Formerly incarcerated individuals with Medicaid coverage have 16% fewer detentions in the year following release [22].

Economy

Because the federal government pays 90% of the cost for beneficiaries enrolled in Medicaid under expansion, closing the coverage gap will bring an influx of federal dollars into the state. A 2019 report estimated that, if North Carolina expanded Medicaid at the end of that year, it would have brought in $11.7 billion in federal funding between 2020 and 2022. Expansion would have created 37,200 additional jobs in 2022 and grown the state's economic output by $2.9 billion in 2022 [23].

Parents who work over a certain number of hours make too much to be eligible for Medicaid, with the benefit structure actually discouraging work. Indeed, expansion has been linked to an uptick in labor force participation. In Michigan, employment status among Medicaid expansion enrollees grew in the two to three years after expansion, from 54.3% to 60% [24]. Montana saw similar gains, with labor force participation among low-income nonelderly Montanans increasing six to nine percentage points following expansion [25].

Growing Support for Expanding Coverage

North Carolina legislators reached a major milestone on the path toward expanded coverage in 2021. As part of the enacted state budget, legislators extended postpartum Medicaid benefits from 2 to 12 months following childbirth. This was a critical step toward addressing North Carolina's higher-than-average maternal mortality rate [26]. As 12% of postpartum deaths occur more than six weeks postpartum, it is a step likely to save the lives of many mothers [27].

Demonstrating a commitment to children and families, legislators extended coverage for low-income parents whose children end up in the foster care system. In the past, a parent whose child was placed in foster care would lose Medicaid eligibility. This new provision allows parents access to care so that they can obtain substance use and mental health treatment. Combined, these two new provisions have ensured continued access to Medicaid coverage for an estimated additional 38,500–40,500 parents (North

Carolina Department of Health and Human Services, email communication, December 6, 2021).

Most importantly, legislators provided a clear path forward through the creation of an 18-member Joint Legislative Committee on Health Care Access and Medicaid Expansion [28]. This committee held the first of numerous scheduled meetings on February 18, addressing multiple issues of health care access with a strong emphasis on Medicaid expansion.

A clear shift in the political environment has been present both in and out of the committee room. Senate leadership has moved from a place of vocal opposition as recently as mid-2020 to publicly expressing an openness to legislation to expand Medicaid, and it appears that expansion was on the table in the most recent budget discussions until the very end.

In the House, it is notable that many key health committee members have worked toward a solution in the past. The last proposed legislation, the NC Healthcare for Working Families Program (HB 655), garnered the support of 22 Republican cosponsors in 2019, including all the sitting House Health Chairs [29]. While the caucus makeup looks different today than in 2019, many of the lead supporters of that bill continue to serve in the legislature.

A key factor in the growing support for Medicaid expansion stems from the 2021 federal American Rescue Plan Act (ARPA) [30]. Under ARPA, states that choose to expand Medicaid will receive a five-percentage-point increase in the federal match rate for the entire Medicaid program for two years following implementation. For North Carolina, this would bring an estimated $1.7 billion in additional federal funds into the state [31].

Federal law dictates that the federal government will contribute 90% of the cost of Medicaid for the expansion population. Currently, non-expansion reimbursement is 66.66%. North Carolina proposals, to this point, have all included assessments on providers and managed care plans to fully cover the state share. This, combined with the new ARPA incentive, removes many of the previous cost concerns.

A final contributing factor has been the growth in conservative support both among key conservative leaders and Republican base voters. In the fall of 2021, five Republican-majority county commissions in Western North Carolina passed resolutions in support of closing the coverage gap [32]. A late October 2021 state poll of Republican primary voters, conducted by conservative pollsters, found a solid majority of those Republican voters support Medicaid expansion [33]. This growing conservative support suggests that Medicaid expansion may be in North Carolina's future.

Conclusion

When the ACA passed, those who had been working to find an affordable solution for covering the uninsured breathed a sigh of relief. It was thought that, finally, there would be a comprehensive solution that would complement our existing private insurance market, giving low-income workers—many of whom did not have employer-paid health insurance—the opportunity to access an affordable insurance plan. Sadly, this did not happen. If North Carolina is to obtain the ambitious goals of Healthy NC 2030, including access to affordable health care, then the state's General Assembly must create a solution to close the coverage gap. It is long past time. NCMJ

Erica Palmer Smith, MA executive director, Care4Carolina, Raleigh, North Carolina.
Kathryn Horneffer, MPH research assistant, Care4Carolina, Raleigh, North Carolina.
Peg O'Connell, JD chair, Care4Carolina, Raleigh, North Carolina.

Acknowledgments

Disclosure of interests. The authors are all associated with Care4Carolina, a coalition advocating to close the coverage gap in North Carolina.

References

1. North Carolina Department of Health and Human Services and North Carolina Institute of Medicine. Healthy North Carolina 2030: A Path Toward Health. NCIOM; January 2020. Accessed February 25, 2022. https://nciom.org/wp-content/uploads/2020/01/HNC-REPORT-FINAL-Spread2.pdf
2. Rockefeller Harris L, Khachaturyan S, Dreier A. U.S. Census Bureau releases data on health insurance coverage in N.C. News release. North Carolina Justice Center. Published September 15, 2020. Accessed February 25, 2022. https://www.ncjustice.org/u-s-census-bureau-releases-data-on-health-insurance-coverage-in-n-c/
3. Tewarson H, Richard D, Moody G. North Carolina Council on Health Care Coverage: First Council Meeting. Presented at: North Carolina Council on Health Care Coverage; December 4, 2020. Accessed February 25, 2022. https://healthpolicy.duke.edu/sites/default/files/2020-12/NC%20Council%20on%20Health%20Care%20Coverage%20-%20Meeting%201%20Compiled%20Slides.pdf
4. United States Census Bureau. American Community Survey Tables for Health Insurance Coverage, Table HI-05_ACS. Accessed March 11, 2022. https://www.census.gov/data/tables/time-series/demo/health-insurance/acs-hi.html
5. Kaiser Family Foundation. Who Could Medicaid Reach with Expansion in North Carolina? KFF. Accessed February 25, 2022. https://files.kff.org/attachment/fact-sheet-medicaid-expansion-NC
6. Garfield R, Rudowitz R, and Damico A. How Many Uninsured Adults Could Be Reached If All States Expanded Medicaid? Kaiser Family Foundation website. Published June 25, 2020. Accessed February 25, 2022. https://www.kff.org/report-section/how-many-uninsured-adults-could-be-reached-if-all-states-expanded-medicaid-tables/
7. Alker J, Corcoran A. *A Profile of North Carolina's Low-Wage Uninsured Workers*. Georgetown University Health Policy Institute Center for Children and Families; April 2021. Accessed February 25, 2022. https://ccf.georgetown.edu/wp-content/uploads/2021/04/NC-Low-Wage-Workers-UPDATE.pdf
8. Chart Book: The Far-Reaching Benefits of the Affordable Care Act's Medicaid Expansion. Center on Budget and Policy Priorities. Published October 21, 2020. Accessed February 25, 2022. https://www.cbpp.org/research/health/chart-book-the-far-reaching-benefits-of-the-affordable-care-acts-medicaid-expansion
9. Guth M, Garfield R, Rudowitz R. The Effects of Medicaid Expansion under the ACA: Studies from January 2014 to January 2020. Kaiser Family Foundation. Published March 17, 2020. Accessed February 25, 2022. https://www.kff.org/report-section/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-report/
10. Zhao J, Han X, Nogueira L, Jemal A, Yabroff KR. Association of state Medicaid income eligibility limits and long-term survival after cancer diagnosis in the United States. *JCO Oncol Pract*. 2022;7(OP2100631). doi: 10.1200/OP.21.00631
11. Khatana SAM, Bhatla A, Nathan AS, et al. Association of Med-

icaid expansion with cardiovascular mortality. *JAMA Cardiol*. 2019;4(7):671–679. doi: 10.1001/jamacardio.2019.1651
12. Searing A, Ross DC. *Medicaid Expansion Fills Gaps in Maternal Health Coverage Leading to Healthier Mothers and Babies*. Georgetown University Health Policy Institute Center for Children and Families; May 2019. Accessed February 25, 2022. https://ccf.georgetown.edu/wp-content/uploads/2019/05/Maternal-Health-3a.pdf
13. Eliason EL. Adoption of Medicaid expansion is associated with lower maternal mortality. *Women's Health Issues*. 2020;30(3):147–152. doi: 10.1016/j.whi.2020.01.005
14. Sullivan J, Bailey A. To Improve Behavioral Health, Start by Closing the Medicaid Coverage Gap. Center on Budget and Policy Priorities. Published October 4, 2021. Accessed February 25, 2022. https://www.cbpp.org/research/health/to-improve-behavioral-health-start-by-closing-the-medicaid-coverage-gap#_ftn26
15. UNC Cecil G. Sheps Center for Health Services Research. Rural Hospital Closures since January 2005. Accessed February 25, 2022. https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/
16. Topchik M, Gross K. Pinette M, Brown T, Balfour B, Kein H. *The Rural Health Safety Net Under Pressure: Rural Hospital Vulnerability*. The Chartis Center for Rural Health; February 2020. Accessed February 25, 2022. https://www.chartis.com/forum/wp-content/uploads/2020/02/CCRH_Vulnerability-Research_FiNAL-02.14.20.pdf
17. Polsky D, Candon M, Saloner B, et al. Changes in primary care access between 2012 and 2016 for new patients with Medicaid and private coverage. *JAMA Intern Med*. 2017;177(4):588–590. doi: 10.1001/jamainternmed.2016.9662
18. Tipirneni R, Rhodes KV, Hayward RA, Lichtenstein RL, Reamer EN, Davis MM. Primary care appointment availability for new Medicaid patients increased after Medicaid expansion in Michigan. *Health Aff (Millwood)*. 2015;34(8):1399–1406. doi: 10.1377/hlthaff.2014.1425
19. Zaller ND, Cloud DH, Brinkley-Rubinstein L, Martino S, Bouvier B, Brockmann B. Commentary: the importance of Medicaid expansion for criminal justice populations in the south. *Health & Justice*. 2017;5(2). doi: 10.1186/s40352-017-0047-0
20. Vogler J. Access to healthcare and criminal behavior: evidence from the ACA Medicaid expansions. *J Pol Anal Mgmt*. 2020;39(4):1166–1213. doi: 10.1002/pam.22239
21. Simes JT, Jahn JL. The consequences of Medicaid expansion under the Affordable Care Act for police arrests. *PLoS One*. 2022;17(1):e0261512. doi: 10.1371/journal.pone.0261512
22. Guyer J, Bachrach D, Shine N. *Medicaid Expansion and Criminal Justice Costs: Pre-Expansion Studies and Emerging Practices Point Toward Opportunities for States*. State Health Reform Assistance Network, Manatt Health, and Robert Wood Johnson Foundation; November 2015. Accessed February 25, 2022. https://www.shvs.org/wp-content/uploads/2015/11/State-Network-Manatt-Medicaid-Expansion-and-Criminal-Justice-Costs-November-2015.pdf
23. Ku L, Bruen B, Brantley E. *The Economic and Employment Benefits of Expanding Medicaid in North Carolina: June 2019 update*. Center for Health Policy Research, The George Washington University; June 2019. Accessed February 25, 2022. https://www.conehealthfoundation.com/app/files/public/621ee3b4-cb3f-4854-a9a8-7af04fd2166b/expanding-medicaid-in-north-carolina---2019.pdf
24. Tipirneni R, Ayanian JZ, Patel MR, et al. Association of Medicaid expansion with enrollee employment and student status in Michigan. *JAMA Network Open*. 2020;3(1):e1920316. doi: 10.1001/jamanetworkopen.2019.20316
25. Bureau of Business and Economic Research. *The Economic Impact of Medicaid Expansion in Montana*. University of Montana; April 2018. Accessed February 25, 2022. https://www.bber.umt.edu/pubs/health/MedicaidExpansionImpact2018.pdf
26. Cantu NV, Lhamon CE, Adams JC, et al. *Racial Disparities in Maternal Health*. U.S. Commission on Civil Rights; September 2021. Accessed March 1, 2022. https://www.google.com/url?q=https://www.usccr.gov/files/2021/09-15-Racial-Disparities-in-Maternal-Health.pdf&sa=D&source=docs&ust=1645830402085888&usg=AOvVaw1H4QPeHM4BQBgII41TI-IC
27. Tikkanen R, Gunja MZ, FitzGerald M, Zephyrin L. Maternal Mortality and Maternity Care in the United States Compared to 10 Other Developed Countries. The Commonwealth Fund. Published November 18, 2020. Accessed February 25, 2022. https://www.commonwealthfund.org/publications/issue-briefs/2020/nov/maternal-mortality-maternity-care-us-compared-10-countries
28. Joint Legislative Committee on Access to Healthcare and Medicaid Expansion. North Carolina General Assembly. Accessed March 12, 2022. https://www.ncleg.gov/Committees/CommitteeInfo/NonStanding/6770
29. H.R. 655, 2019 Reg. Sess (NC 2019). https://www.ncleg.gov/BillLookup/2019/h655
30. The White House. American Rescue Plan. Access March 12, 2022. https://www.whitehouse.gov/american-rescue-plan/
31. Collins M. Medicaid Expansion Fiscal Background. Presented at: Joint Legislative Committee on Access to Healthcare and Medicaid Expansion; March 1, 2022. Accessed March 12, 2022. https://www.ncleg.gov/documentsites/committees/BCCI-6770/Meetings/2022.03.01/Item%203b%20-%20Medicaid%20Expansion%20Fiscal%20Background_FRD_3-1-2022.pdf
32. Care4Carolina. Civic Leaders. Accessed March 12, 2022. https://care4carolina.com/civic-leaders/
33. Shumaker P, Stewart D. October 26-28, 2021 Survey Findings. Strategic Partners Solutions, LLC; November 2, 2021. Accessed March 12, 2022. https://ncchild.org/wp-content/uploads/2021/11/NC-Child-Polling-Memo-11.2.2021-FINAL.pdf