ISSUE BRIEF

North Carolina's Uninsured

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Most people in the United States have health insurance coverage through their employers. More than 61% of the non-elderly in this state have employer-sponsored insurance (ESI). The connection between health insurance coverage and employment dates back to World War II, when Congress passed the Labor Stabilization Act (1942), which restricted employers from offering wage increases to attract workers. The Act restricted wage increases, but did not limit the use of non-wage benefits. As a result, many employers began offering health insurance as a means of competing for scarce workers. The connection between employment and health insurance coverage was solidified in 1954, when the Internal Revenue Service ruled that employer contributions to health benefits plans were non-taxable benefits to employees. Health insurance purchased outside an employer-based system has never been afforded the same tax advantage.

While most people obtain health insurance coverage through their employers, this connection has grown more tenuous in recent years. The percentage of non-elderly people with employer-sponsored insurance declined by nine percentage points in North Carolina, from 67.6% (in 1999-2000) to 61.5% (2003-2004). Nationally, there was only a six percentage point decline in employer-sponsored insurance in the same period, from 67.6% to 63.3%.[1] At the same time, there has been a 15% increase in the percentage of people with public coverage in North Carolina (from 17.3% in 1999-2000 to 20% in 2003-04), but this increase has not been sufficient to offset the loss of employer-sponsored insurance. The percentage of people with private, non-group coverage has remained relatively constant over the years.

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The decline in employment-based coverage has led to a sharp growth in the numbers and percentage of uninsured. Since 1999-2000, the percentage of North Carolinians without health insurance coverage increased 15%, compared to a 10%

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increase nationally. This growth in both the number and percentage of uninsured is not part of the normal ebb and flow of insurance coverage. In 2003, North Carolina experienced the largest increase in both the numbers and percentage of people without coverage in any five-year period in the state's history since 1992. The year 2004 saw a slight rebound in the percent who were uninsured, but in general, there is still an upward trend in the percentage of people without coverage. In 2003-2004, approximately one out of every six people under the age of 65, or 1.3 million people, lacked health insurance coverage in North Carolina. While this problem is not unique to North Carolina, our state appears to have been disproportionately affected by the loss of coverage. The percentage of the state's population without health insurance has grown more rapidly in North Carolina than in most of the other states in the country.

There have been many reasons posited to explain this large increase in the numbers of North Carolina's uninsured. Studies show that the primary reason for the increase in the numbers of uninsured is rising health insurance premiums.[2] The downturn in the economy during the early part of this decade also contributed to the increase in the numbers of uninsured.[3] Extensive job losses in manufacturing and the simultaneous growth in the service sector have contributed to this problem. Regardless of the reason, North Carolina is now faced with more than a million people who lack insurance coverage.

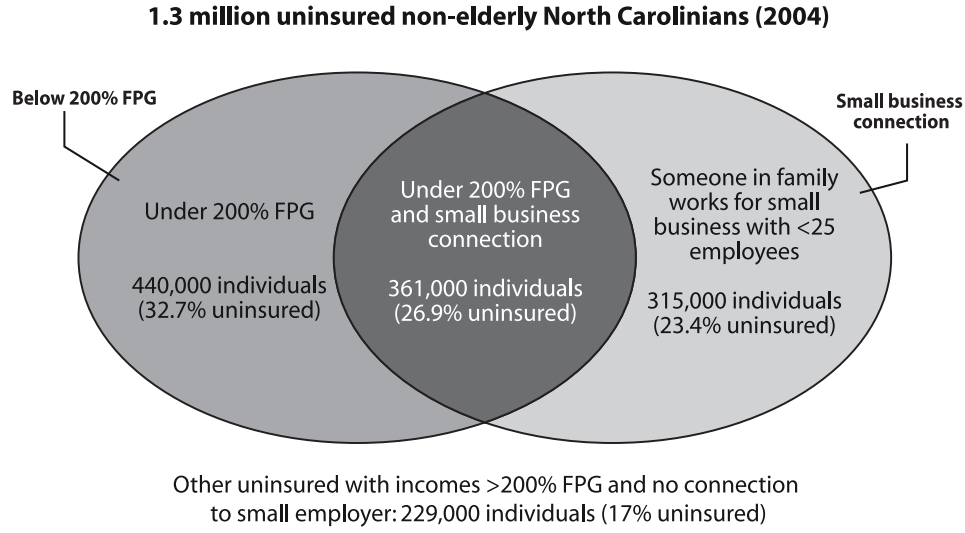
People who lack insurance coverage have a harder time obtaining needed healthcare, and as a consequence, their health suffers. But the rising numbers of uninsured have broader societal implications. Workers who are in poor health are less productive, children who are sick miss more days of school, and the growing numbers of uninsured are creating an economic strain on the healthcare institutions that care for everyone.

In 2004, the North Carolina Department of Health and Human Services (NC DHHS) obtained a State Planning Grant from the United States Department of Health and Human Services, Health Resources and Services Administration to analyze the numbers of uninsured and develop policy options to address this problem. In this effort, the NC DHHS partnered with the North Carolina Department of Insurance (NC DOI), the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill, and the North Carolina Institute of Medicine (NC IOM). As part of the State Planning Grant project, the NC IOM convened a task force to examine options to expand health insurance coverage to the uninsured. This issue brief describes the findings as well as some of the policy options considered by the Task Force. First, the issue brief describes the uninsured and the health consequences from lacking health insurance coverage. The issue brief also presents some of the reasons for rising healthcare costs and concludes with several options to expand coverage and healthcare services to the uninsured.

The Demographics of the Uninsured

In many ways, the uninsured are a microcosm of the state's population. They include workers and the unemployed; wealthy and low-income individuals; and men, women, and children of all races, ethnicities, and ages. Yet, while the uninsured are a broad cross-section of the state's population, there are certain groups that are more likely than others to be uninsured. More than four fifths (83%) of the uninsured fall into one or both of two groups: (1) those having someone in the family working for a small employer (an employer with 25 or fewer workers) or (2) those having a family income less than 200% of the federal poverty guidelines (FPG).[1]

Figure 1.
Uninsured in North Carolina: Primarily Those with Low Income or Employees of Small Firms



A common misperception about why people lack insurance coverage is because they do not work or have no connection to the workforce. In fact, more than three fourths (78%) of the uninsured are in families where someone is working full time, and one third (33%) are in families where two people are working full time. The size of a person's employer workforce is a major determinant of whether or not a person has health insurance coverage. Small firms, particularly those with fewer than ten employees, are far less likely to offer insurance than larger employers (see Table 1). Approximately half (55.3%) of the uninsured, or 776,000 North Carolinians, are employed by or in a family with someone who works for a small firm (with fewer than 25 employees). Connie Majure-Rhett and Kristen Dubay provide further insight into the

Table 1.
Percent of Firms that Offer Health Insurance, by Size of Firm (2002-2003)

Size of Employer	NC	US
Total	53.6%	56.7%
<10 employees	29.4%	36.2%
10-24 employees	67.5%	67.0%
25-99 employees	79.3%	81.7%
100-999 employees	99.3%	94.5%
1000+ employees	98.9%	98.7%

Source: Agency for Healthcare Research and Quality. Center for Financing, Access and Cost Trends. 2003 and 2002 Medical Expenditure Panel Survey – Insurance Component. Table II.A.3.

problems that small employers have in paying for health insurance in their commentary in this issue of the Journal.[4] The type of industry also impacts on insurance coverage as certain industries —particularly construction and agriculture—are less likely than other industries to offer health insurance.

Almost 60% of the uninsured, or 801,000 North Carolinians, have family incomes below 200% FPG, or $38,700 for a family of four in 2005.[5] While most of these individuals are workers, they are less likely than those with higher incomes to work full time, and they are more likely to work in industries that have lower rates of insurance coverage. Even if they are offered coverage, the employees' share of the cost may be too burdensome. The average total cost for employer-sponsored insurance in North Carolina was more than $3,200 per year for an individual employee and $8,200 for family coverage in 2002-2003.[a] The average employee-share of health insurance premiums in North Carolina was $558 for individual coverage and $2,200 for family coverage. Based on these figures, the average employee premium costs for a family living in poverty would be 12% of their gross income, or 6% for a family living at 200% FPG, not including other out-of-pocket expenses, such as deductibles, coinsurance, or copayments. Health insurance premiums are generally more expensive in the non-group market for similar coverage. Thus, individuals who do not have access to employer-sponsored insurance may have to spend more money if they try to purchase a comprehensive policy directly from an insurer. Adam Searing, Project Director of the North Carolina Healthcare Access Coalition, a consumer advocacy group, describes a research-based approach to effective policy advocacy on behalf on the uninsured population later in this issue of the Journal.[6]

In addition to those who have low incomes or work for a small employer, there are other groups that are more likely than the general public to lack insurance coverage. Racial and ethnic minorities have a much greater likelihood of being uninsured than do whites. Approximately 14% of white, non-Latinos are uninsured, compared to 18% of black, non-Latinos and 54% of Latinos. Many people believe that the growth in the Latino population has driven the rise in the uninsured in North Carolina. However, it is generally not the growth in the Latino population—or any racial or ethnic group per se—that drives our uninsurance rates; it is their relatively low income and access to employer-sponsored insurance or public coverage. This subject is more thoroughly discussed by Dr. Holmes in a commentary on page 202 of this issue of the Journal.[7]

Other groups that have a greater likelihood of being uninsured include young adults and those living in rural areas. Young adults ages 18-34 are more likely than those who are older or younger to lack coverage. Approximately 29% of young adults lack coverage, compared to 11% of children under age 18, 15% of those age 35-64, and less than 1% of those age 65 or older. Children are less likely to be uninsured than most adults because they have greater access to publicly subsidized insurance (either Medicaid or North Carolina Health Choice).

People living in rural areas are also disproportionately more likely to be uninsured than those living in urban areas (21% versus 17%, respectively). Given that the uninsured rate varies considerably by age, industry, firm size, and rurality, it is no surprise that the uninsured rate varies markedly across North Carolina. The Running the Numbers section of this issue includes county-level data on the uninsured. The county with the lowest uninsured rate in 2004 was Wake (13.9%), and the county with the highest (Tyrrell) had over double this rate at 28.3%. The demographic and socioeconomic characteristics of the county's population have considerable influence on the likelihood of residents to lack health insurance (see page 235).[8]

Health Effects of Being Uninsured

The uninsured are more likely to report being in fair or poor health, but are less likely to receive needed healthcare services. A rich body of research literature documents the adverse health impact from lacking insurance coverage. The Institute of Medicine of the National Academies did a meta analysis of research studies analyzing the impact of being uninsured (2002),[9] as did Jack Hadley for the Kaiser Commission on Medicaid and the Uninsured.[10] In addition, we have North Carolina-specific data that document the impact of being uninsured on access to health services and avoidable hospitalizations.

Uninsured North Carolinians are much more likely than people with insurance coverage to report healthcare access barriers. The State Center for Health Statistics, within the NC DHHS,

a The full cost of employer-sponsored insurance—absent any employer contribution—would constitute 36% of the gross income of an individual living in poverty for individual coverage and 18% for a person living at 200% FPG. For a family of four living in poverty, the total cost of employer-sponsored insurance for a family would constitute 45% of their gross income, 22.5% for a family of four living at 200% FPG.

b The BRFSS is national health risk survey developed by the Centers for Disease Control and Prevention (CDC) and amended by individual states. It is administered and supported by the Division of Adult and Community Health, National Center for Chronic Disease Prevention and Health Promotion, CDC, and is an ongoing data collection program. All states, the District of Columbia, and three territories participate in the BRFSS.

is a participant in the Behavioral Risk Factor Surveillance Survey (BRFSS)[b] annually, a telephone survey of 15,000 adults across the state. Uninsured North Carolinians in 2004 were more likely to report they had no personal physician or healthcare provider (52%) compared to people who had insurance (13%).[11] They are four times more likely than people with insurance to report that there were times in the last 12 months when they needed to see a doctor, but could not due to the costs (44% versus 11%, respectively). Uninsured people with diabetes were more likely to report that there were times in the last 12 months when they could not afford their testing strips for diabetes due to the costs (49% versus 16%, respectively). Similarly, people without coverage are less likely to obtain preventive screenings, such as mammograms, prostate specific antigen (PSA) screenings, or colorectal screenings, than those with insurance coverage. North Carolina hospital discharge data show that the uninsured are more likely to be hospitalized for preventable conditions than those with private insurance coverage.[12] For example, the uninsured are 50% more likely to be hospitalized for asthma than those with insurance.

The national data also show access barriers similar to what we found in North Carolina. However, national studies have also been able to examine the effect that lack of coverage has on health outcomes. National data show that the uninsured are more likely to delay care and, as a result, be diagnosed with more advanced health problems, such as late-stage cancer. Those with chronic diseases are less likely to obtain the treatment or medications they need to manage their chronic illnesses. And, similar to North Carolina data, national data confirm that the uninsured are more likely to end up in the hospital for preventable conditions. Because of these access barriers, the national Institute of Medicine estimated that being uninsured increases the risk of dying prematurely by 25% over rates for those with insurance coverage.

Lack of insurance coverage affects more than the specific person's health status. The growing numbers of uninsured affect everyone. Children who are sick miss more school days and may have a harder time keeping up with school work. Workers in poor health are less likely to work or may work fewer hours. Research shows that workers with insurance coverage take fewer sick days and have shorter episodes of illness than workers who are uninsured.[13] The uninsured in North Carolina are more likely to report difficulties paying their medical bills, being contacted by a credit agency, and having to cut back on other living expenses—such as utilities, food, clothing, housing, or transportation—to pay for their medical bills.[12] Outstanding medical bills, in turn, are a leading cause of bankruptcy.[14] Further, the costs of providing health services to the uninsured are "shifted" to those with private insurance coverage, leading to higher premium costs. One study suggested that the costs of caring for the uninsured in North Carolina have led to a $438/year increase in employer-sponsored insurance premiums for individuals and a $1,130 increase for families.[15] In addition, the growing costs of caring for the uninsured are creating a financial strain on the healthcare institutions that serve everyone regardless of insurance status. William Pully, President of the North Carolina Hospital Association, describes the financial impact of the rising numbers of uninsured on hospitals across the state in his commentary in this issue of the Journal.[16]

Rising Healthcare Costs Are Leading to the Increased Numbers of Uninsured

Between 2000 and 2004, health insurance premiums have increased 65% nationally, far faster than wages (12.2%) or general inflation (9.7%).[17] These rising premiums are a major contributor to the increasing numbers of uninsured. More than half (55%) of the uninsured surveyed in North Carolina reported that they didn't have health insurance because it costs too much, and another 23% reported that they were out of work or between jobs, which could also make health insurance coverage unaffordable.[11] Similarly, 86% of employers who did not offer health insurance reported in a national survey that high premium costs were an important reason for not offering coverage.[18] Every 10% increase in premiums leads to a 2.5% decline in employers offering coverage, with smaller firms being more responsive to premiums than larger firms.[19]

In order to stem the increasing numbers of uninsured, it is also important to address rising healthcare costs. While there are many factors that lead to increased premiums, the primary driver is the increase in underlying healthcare costs.[c,20,21] We, as a society, are using more healthcare services, while at the same time, the underlying costs of many of these services have increased. The advent of new technology and treatment protocols, changes in overall disease prevalence or changing demographics, the costs of defensive medicine, and underlying labor costs all contribute to rising healthcare costs. One study showed that almost one third of the change in healthcare spending between 1987 and 2000 was attributable to the treatment of five major health problems: heart disease, mental disorders, pulmonary disorders, cancer, and trauma. Half of the increase was attributable to 15 conditions.[22] Many of these health conditions are exacerbated by our lifestyles or lifestyle-related diseases, including obesity, smoking, and problem drinking.[23] Sandra Greene, a Senior Research Fellow at the Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, provides more information about the reasons for the increased healthcare expenditures in her commentary on page 192 in this issue of the Journal.[24]

Employers have responded to these rising premium costs by

c One way of determining the extent to which underlying healthcare costs are driving premium increases versus underwriting profits of insurance companies is to compare the premium increases of fully-insured plans versus self-funded plans, as the premium costs in self-funded plans almost exclusively relate to underlying costs of medical claims. Studies that have compared the premium increases to determine the effect of insurance underwriting profits on premiums found almost no effect of underwriting profits between the springs of 2004 and 2005. Underwriting profits did play more of a role on the premium increases in the prior year, when premiums for fully insured plans increased 11.2%, but medical claims expenses only rose 7.4%.[19,20]

shifting more of the costs to their employees, either through higher premiums, deductibles, or other out-of-pocket spending. Between 2000-2005, the employee's share of health insurance premiums increased by 82%, with a 67% increase in family coverage.[25] One fifth of all employers are offering high-deductible plans, which have at least a $1,000 deductible for individuals and a $2,000 deductible for family coverage. Employers have also tied the increased cost-sharing to the services that are contributing significantly to rising healthcare costs, such as inpatient hospitalizations and prescription drug use.

In addition, more employees are now covered by plans that offer case management or disease management for high-cost and chronic health conditions. A small percentage of the population accounts for the majority of spending on healthcare. In 1996, for example, approximately 5% of the population accounted for 55% of all spending on healthcare, and 30% of the people accounted for 90% of healthcare spending.[26] Thus, 81% of employees with employer-sponsored insurance are in plans that use case managers to manage high-cost claims; and 56% of workers are in plans that offer at least one disease management program.[25]

Incremental Reform Efforts

Ultimately, the only way to fully address the problems of the uninsured is to ensure that every person has health insurance coverage. Offering health insurance on a voluntary basis creates incentives for adverse selection. In other words, people who are less healthy and likely to incur healthcare costs are more likely to enroll and pay for health insurance than those who are healthier. Thus, lower participation rates and a population of higher-risk individuals will increase the average cost per eligible.

Nonetheless, it is difficult to achieve universal coverage on a state-level basis; to date, no state has been able to fully insure its population. Further, the Task Force realized early in its deliberations that no single approach to providing universal coverage would gain the support of the different healthcare constituencies. Thus, the Task Force recommended a multi-pronged approach that included market-based reform efforts, private-public partnerships, and public initiatives to expand coverage to more of the uninsured.

The Task Force's priority recommendations focused on five areas:

- Expand the healthcare safety net to provide healthcare services to more uninsured.
- Promote personal responsibility for health to help improve population health.
- Create a lower-cost health insurance product for small employers who have not offered health insurance in the past.
- Develop a limited-benefit Medicaid expansion plan for low-income parents.
- Create a high-risk pool for individuals with pre-existing health problems.

Expand the Healthcare Safety Net

Many people are under the mistaken belief that people can get the healthcare they need, even if they do not have insurance. Under the federal Emergency Medical Treatment and Active Labor Act (EMTALA), hospitals are required to screen and stabilize anyone who seeks care in their emergency department.[d] However, this is not the most appropriate, nor is it the least costly, way for people to receive care. The North Carolina Institute of Medicine Safety Net Task Force examined the availability of safety net organizations that provide primary care services to the uninsured on a sliding-fee scale basis, such as community and migrant health centers, free clinics, public health departments, state-funded rural health clinics, or other non-profits with a mission to serve the uninsured.[27] Private physicians also provide care to the uninsured, often on a reduced cost basis. The Task Force found that these organizations are not available in every county. Statewide, only about 25% of the uninsured received care through a healthcare safety net organization. Further, national studies show that less than half of the uninsured are aware of safety net resources in their communities.[28] Safety net providers are also limited in the care they can provide, as many are unable to provide needed behavioral health or dental health services, specialty care, or access to necessary medications. In this issue of the Journal, Annette DuBard, a primary care physician working at a community health center in Alamance county, describes some of the frustrations and heartbreak she faces as a physician trying to address the healthcare needs of her uninsured patients.[29]

The North Carolina Institute of Medicine Task Force on Covering the Uninsured recognized that its recommendations would not lead to universal coverage for all of the uninsured. Thus, safety net services are needed to ensure that those who continue to lack coverage will have some access to services. **The NC IOM Task Force on Covering the Uninsured recommended that the North Carolina General Assembly increase funding to support and expand the healthcare safety net in order to provide services to more of the uninsured.**

Promoting Personal Health Responsibility to Improve Population Health

Lifestyle choices and lifestyle-related diseases contribute to the rising costs of healthcare. Smoking, heavy drinking, and obesity can lead to chronic health problems and, as a result, increased healthcare costs. For example, obese people have a higher risk of developing diabetes, hypertension, and heart disease. Smokers have a greater likelihood of developing lung cancer or heart disease. Problem drinkers have a higher risk of trauma through falls and motor vehicle accidents, and are at increased risk for pancreatitis and certain types of congestive heart failure. According to 2001 figures, 24% of the United States population is obese, an increase of ten percentage points since 1987.[30] The increased prevalence of obesity alone

d EMTALA requires hospitals that participate in Medicare to screen anyone who requests treatment at the emergency department, regardless of ability to pay. 42 USC §1395dd.

accounted for 12% of the real per capita healthcare spending growth between 1987 and 2001.

One of the best strategies to reduce the rapid escalation in healthcare spending is to encourage people to live healthier lifestyles. On page 225 in this issue of the Journal, Robert Greczyn, President and CEO of Blue Cross and Blue Shield of North Carolina, presents ideas on how we can control healthcare costs in North Carolina.[31] The incidence of chronic diseases and, over the longer-term, the rate of growth in healthcare spending, could be decreased if people would eat healthier foods, exercise regularly, maintain a healthy weight, and reduce other risky behaviors. Thus, one of the Task Force's recommendations was to focus on improving population health. People have a responsibility to be better stewards of their own health, but society at large can help in that effort. **Specifically, the Task Force recommended that individuals be given the education, support, and resources needed to make informed healthy lifestyle choices; that individuals with chronic diseases be provided the information and access to health services needed to manage their conditions; and that individuals who engage in unhealthy behaviors be expected to pay differential premiums to cover some of the increased healthcare costs of their lifestyle choices. Further, the Task Force recommended that providers, employers, insurers, schools, and government all assist in promoting healthy lifestyle choices and encourage people to participate in evidence-based wellness initiatives.**

Low-cost Health Insurance Product for Small Employers

The Task Force focused on ways to reduce premium costs for small employers, as half of the uninsured have a family connection to a small employer. North Carolina's small-firm employees are less likely to be offered health insurance by their employer than nationally, but those who are offered insurance are more likely to enroll.[32] Focus groups with North Carolina employers, conducted by FGI Research as part of the State Planning Grant, confirmed that employers want to provide health insurance coverage to their employees. "We like to keep our employees healthy so they'll show up for work," noted one focus group participant. However, high premium costs were cited as the major barrier to offering coverage.

The Task Force focused on different ways to reduce premium costs for small employers. One of the primary ways to reduce costs is to reduce the benefits covered or greatly increase cost-sharing. However, there is a tension between offering pared-down benefit plans or plans with such high cost-sharing that the uninsured would find it unattractive, versus expensive plans that offered comprehensive benefits.

The Task Force's priority recommendation was to offer a publicly-subsidized health insurance product that would be targeted to small employers with 25 or fewer employees, sole proprietors, or employees who are not offered health insurance through their jobs. The state would be urged to provide reinsurance[e] to help reduce the premium costs by 30% over what is available in the private market. To further reduce the potential costs to the state, the proposal would be limited to employers who have not offered health insurance in the last 12 months and who also have a low-wage workforce (i.e., at least 30% of the employees earn $12/hour or less). Eligibility for sole proprietors and working individuals would be limited to those who had not had coverage in the last 12 months and who had family incomes less than 250% FPG. This model is based on the Healthy New York model, which has been in operation since January 2001 and now covers more than 100,000 previously uninsured individuals.[33]

The Task Force also recommended that commercial insurers develop tiered benefit plans, which offer very basic healthcare coverage (i.e., generally limited to a specified number of doctor's visits or have caps on hospitalization costs) at the lowest premium, with more comprehensive benefits and reduced cost-sharing available for a higher premium. While these products are unlikely to appeal to a significant portion of the uninsured, they may be attractive to those who are young and healthy and do not foresee the need for comprehensive coverage. Another recommendation from the Task Force was to review the state's small group reform laws enacted in the 1990s, which helped establish a small group rating methodology to stabilize the small group market. The North Carolina Department of Insurance established a work group to examine these laws to determine if there are potential modifications that could increase coverage among small employer groups. Barbara Morales Burke discusses the work of this committee in her commentary in this issue of the Journal.[34]

Limited-Benefit Health Insurance Product for Low-Income Parents

Three fifths of the uninsured have incomes less than 200% FPG. People with low-incomes have difficulty affording coverage, whether through an employer or in the non-group market. Many low-income people are covered through Medicaid or North Carolina Health Choice (the State Children's Health Insurance Program). For example, in March 2006, there were almost 1.2 million people covered by Medicaid and approximately 105,000 children under the age of 19 covered through North Carolina Health Choice.[35] However, because of categorical, income, and resource restrictions, these programs do not cover all low-income uninsured individuals. The United States Bureau of the Census Current Population Survey estimates that Medicaid and North Carolina Health Choice only cover approximately 35% of people living below 100% FPG, and

e Reinsurance is essentially insurance coverage for insurance carriers. If the annual claims for an individual in the plan reach some predetermined amount, then the reinsurer covers at least some part of the claims above that level. Under the Healthy New York program, the state reimburses private health plans for 90% of the claims costs between $5,000 and $75,000 per individual (called the "reinsurance corridor.") The NC IOM Covering the Uninsured Task Force did not recommend a specific reinsurance corridor, rather it recommended that the reinsurance corridor be set at a level that would result in 30% lower premiums than are available in the private market.

only 20% of those living between 200-200% FPG.[3] In order to qualify for Medicaid, a person must fall into a specified eligibility "category," including pregnant women, children under age 21, parents with dependent children, people with disabilities, or seniors age 65 or older. In addition, individuals must have incomes below a certain income limit; and, depending on the eligibility category, the person may have to meet certain resource restrictions (e.g., amount of money in the bank). Childless adults who are younger than 65 and not disabled will not qualify for Medicaid, regardless of how poor they are.

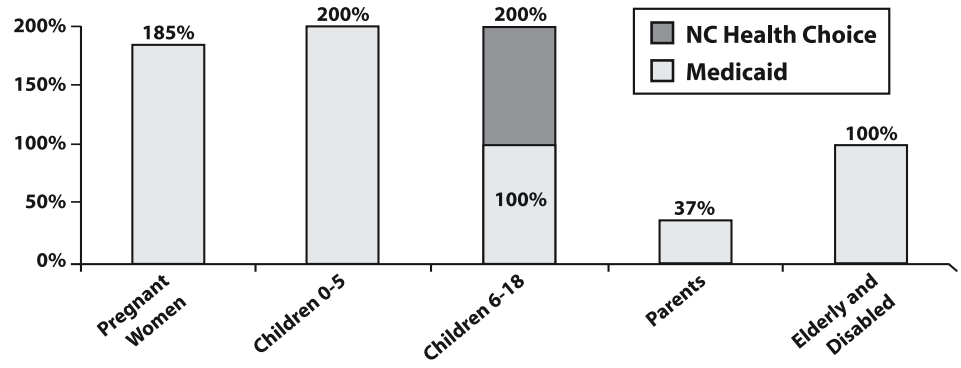
The Task Force explored different options to expand Medicaid to cover more low-income people. This is a lower-cost option to the state than developing a 100% state-funded program, as the federal government pays approximately 63% of program costs. North Carolina's income eligibility rules are comparable to or higher than many other states for pregnant women, children, older adults, and people with disabilities. However, North Carolina's income eligibility thresholds for parents, which limit their countable income to 37% FPG, are among the lowest in the country (see Figure 2).[36]

The Task Force's top priority for Medicaid expansion was to cover parents and pregnant women with incomes up to 200% FPG. In order to limit the cost to the state, the Task Force suggested that the state seek a waiver of the traditional Medicaid laws to design a more limited benefit package. The limited benefit package would focus on ambulatory care, with incentives for people to participate in disease and case management to help them manage their chronic health problems. Inpatient hospitalization would be limited to $10,000 total/year, and covered individuals would be expected to pay a sliding-scale premium and cost-sharing for the services they receive. Unlike traditional Medicaid, this expansion would not be an entitlement, so the state would have limited financial liability for the coverage. The Task Force decided to focus on Medicaid expansion for parents, rather than children, since the income limits for the working adults are so much lower than for children.

Analysis of the United States Bureau of the Census Current Population Survey (CPS) data suggests that there are tens of thousands of uninsured North Carolinians who currently qualify for Medicaid or North Carolina Health Choice, but are not enrolled.[37] National studies show that many people who are eligible for public programs do not enroll because they do not know about the program or eligibility criteria, or because the complicated eligibility process or stigma attached to the programs deter them from applying.[38,39] The NC DHHS has already done a lot to simplify and streamline the application processes. Yet, the Task Force recommended that more be done to increase outreach and simplify the application process to encourage uninsured individuals who are currently eligible to apply for these programs.

Another way to expand care for the uninsured is through the Medicaid Community Care of North Carolina (CCNC) networks. CCNC is comprised of community-based networks designed to improve the care provided to Medicaid recipients. The 14 regional networks cover 92 of the 100 counties and approximately 670,000 Medicaid recipients. Each network includes primary care providers, hospitals, departments of social services, health departments, and other healthcare providers and provide case management and disease management services to help patients manage chronic or high-cost conditions. L. Allen Dobson, Assistant Secretary for Health Policy and Medical Assistance for NC DHHS, discusses the importance of implementing CCNC cost-saving strategies (i.e., quality improvement, disease management, targeted utilization initiatives) along with providing con tinued support for the safety net in his commentary in this issue of the Journal.[40]

Figure 2.
Medicaid Income Eligibility as Percent of Federal Poverty Guidelines (FPG)



High-Risk Pool for People with Pre-Existing Health Problems

Ostensibly, people with pre-existing health problems are among those individuals most in need of health insurance coverage, but they often have the hardest time finding affordable coverage. People with pre-existing health problems cannot be excluded from coverage or charged higher premiums if they obtain their coverage through an employer. However, with limited exceptions, individuals who seek coverage in the non-group market can be denied coverage or charged unaffordable premiums. Later in this issue of the Journal, David Moore, past President of the North Carolina Healthcare Underwriters Association, discusses the merits of creating a high-risk pool in North Carolina.[41]

Blue Cross and Blue Shield of North Carolina is the only insurer in the state to offer health insurance coverage to anyone in the non-group market, regardless of their health status. However, premiums vary, based on the age, geographic location, sex, and health status of the individual. The premiums are established to cover the anticipated costs of the group of enrollees—thus, those with pre-existing problems are charged

higher premiums than those who are healthy and presumed to use fewer health services. For example, non-group health insurance coverage for a man with significant health problems could cost more than $800/month (for a $1,000 deductible, 30% coinsurance plan), or more than $1,800/month for a 55-year-old man. Premiums for women are generally more expensive, especially if the woman chooses maternity coverage.

Thirty-three states have established high-risk pools to help subsidize the costs of health insurance coverage for people with pre-existing problems. Research suggests that approximately 1% of the non-elderly population has difficulty obtaining insurance due to their health status ("medically uninsurable").[42] The experience from other states suggests that between 10-30% of these individuals may enroll in a high-risk pool, depending on the premium price and whether the state offers additional subsidies for low-income people.[43] Most states cap the premiums charged to individuals enrolled in the high-risk pool to 150% of the standard price charged to healthier individuals. **The Task Force recommended that North Carolina establish a high-risk pool and that the losses from the pool be spread broadly among all insurers, including commercial carriers, third-party administrators, and reinsurance carriers.** Congress appropriated $75 million in grant funds in 2005 to help states offset some of the losses from a high-risk pool.[44] In addition, Congress appropriated another $15 million to provide start-up funds to states, like North Carolina, that have not yet established a high-risk pool.

Conclusion

The problems of the uninsured affect everyone in our state. Individuals stand to benefit by having affordable coverage that enables them to get necessary healthcare services. Providers will gain if there is a source of coverage for those individuals for whom they are already providing some services, but with minimal payments. Businesses benefit by having a healthier, more productive workforce and fewer bankruptcies. The state stands to gain by having a healthier, more competitive workforce and healthier children who are more likely to succeed in school. As more people gain insurance coverage, there will be less uncompensated care. This, in turn, will reduce the need to shift uncompensated costs of serving the uninsured onto people with insurance, which will help moderate rising healthcare costs for those with insurance.

Just as each group stands to gain by expanding insurance coverage to the uninsured, there is a shared responsibility to assist in the solution. Individuals should purchase health insurance when affordable coverage is offered. Employers can assist by offering insurance and helping contribute toward the cost of employee and dependent coverage. Insurers can help by subsidizing the costs of the high-risk pool. Providers can assist by accepting lower reimbursement rates for low-income individuals and small employers who were previously uninsured. And government can assist by helping to subsidize the costs of insurance for those who could not afford coverage in the private market.

The problems of the uninsured beg for a national solution; as it is difficult for any state to tackle this problem in a vacuum. However, states should not wait until the federal government acts. Many states are devising creative solutions to expand coverage to the uninsured. Some states are further along in their process than North Carolina and already have low-cost products for small employers and Medicaid programs that cover more of the uninsured. North Carolina can learn from these states and then develop programs that are tailored to the unique needs and strengths of this state. The Task Force's recommendations are a starting point toward this goal, but additional work will be needed in the future if the state is ever to realize the goal of universal health insurance coverage for all. **NCMedJ**

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