
FORUM

Access to Care for North Carolina's Uninsured

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North Carolina's Uninsured

Lack of insurance is a serious problem that can lead to health problems and financial hardship. Nationally, the uninsured are more than five times more likely to report needing care, but not receiving it, and almost two times more likely to report being unable to fill a prescription due to cost.¹ The uninsured are also more likely not to have a regular source of health care and are more likely to have an avoidable hospitalization for a medical condition, such as diabetes or hypertension.² Because the uninsured postpone care, they are often diagnosed with more serious health conditions. For example, the uninsured are more likely to be diagnosed with later stages of breast, prostate, colorectal, and skin cancer than people with insurance.

Children are also affected by not having health insurance. Uninsured children are less likely than insured children to receive medical attention following an injury. Although more likely than uninsured adults to get needed medical care, uninsured children are still less likely to receive care than insured children. They are also less likely to get needed medication, eyeglasses, mental health care and dental care.³ This paper describes the uninsured in North Carolina and poses different policy solutions to reduce the numbers of uninsured.

Data and Methodology

Data on the uninsured were taken from the March supplement to the Current Population Survey (CPS). Each March, the US Census Bureau collects national data on health insurance coverage. The CPS surveys a sample of families in each state. Respondents are asked if they or anyone in the household were covered by different sources of health insurance at any time in the past year. In the past, the number of uninsured was based on a residual count—that is, a person reporting no other source of health insurance coverage was counted as uninsured. However, beginning with the 2000 CPS survey, respondents were also asked if they had been uninsured for the past year. Respondents who answered no were then re-asked the insurance questions.⁴ While respondents are asked if they had health insurance coverage at any time during the past year, many experts suggest that the responses more closely reflect the insurance status at the time the questions are asked.⁵ Thus, the CPS data reflect the number of uninsured on any given day. Because of the relatively small sample size in North Carolina, the authors combined two years of CPS data in their analyses. Most of the data in this paper were taken from the 1999 and 2000 CPS survey, reflecting 1998 and 1999 numbers of uninsured.

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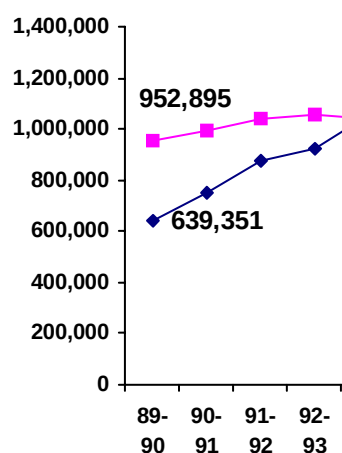


Figure 1. Numbers of North Carolina uninsured and Medicaid recipients, 1990-2000

Who are the Uninsured?

In 2000, there were approximately 1.1 million uninsured on any given day in North Carolina.^{6,7} The total number has grown from 952,895 in 1989-1990 to 1,136,728 in 1999-2000 (see Figure 1), despite a large increase in the number of Medicaid-eligibles,⁸ record low unemployment rates, and low medical cost inflation during much of the last ten years.

Much of the increase in the number of uninsured can be attributed to the state's population growth. The percentage of uninsured has fluctuated between 13.8% and 15.9% of the population. Without the Medicaid expansion and good economy, both the number and percentage of uninsured would likely be much higher.

Close examination of the data reveals that certain groups are much more likely to be uninsured. The poor and working-poor, racial and ethnic minorities, and those who work for small employers have a much higher *risk* of being uninsured. It is important to distinguish between (a) the percentage of uninsured that fall into a given category, and (b) the percentage of any specific group that is uninsured ("risk of being uninsured"). For example, a higher percentage of the uninsured are whites, as whites make up a much greater percentage of NC's population than do African-Americans or other racial minorities. Yet, African-Americans have a much higher chance of being uninsured than do whites. Examining both the risk of being uninsured and the numbers and percentage of uninsured in different categories can lead to different policy interventions.

The poor are more likely to be uninsured. Figure 2 shows the source of insurance coverage for North Carolinians who are grouped according to their family income. The data show that 32% of poor North Carolinians were uninsured. These are people who had annual incomes below 100% of the federal poverty guidelines (FPG) or \$17,050 for a family of

four. This compares to 22.4% of people with incomes between 100-199% of the FPG, 14.8% of those with incomes between 200-399% of FPG, and only 8.0% of those with incomes above 300% of FPG (\$51,150 for a family of three in 2000).

Not only are the poor and near-poor more likely to be uninsured, they also constitute a majority of the uninsured in this state. Nearly 57% of the uninsured in North Carolina have family incomes that are below 200% of the 2000 FPG (\$34,100 for a family of four).

The type of health insurance coverage varies by family income (Figure 2). The poor and near poor are more likely to rely on governmental health insurance programs; whereas those with higher incomes are more likely to rely on private health insurance coverage.

Racial and ethnic minorities are more likely to lack health insurance coverage. According to the 1999-00 CPS data, over one-fifth (21.1%) of blacks, 23.4% of others, and 12.9% of whites were uninsured. The biggest change over the last ten years has been the dramatic increase in the percentage of Latinos who are uninsured: from 23.7% to 41.0% between 1989-90 and 1999-00. Part of the fluctuation in the risk of being uninsured among Latinos may be due to the small CPS sample size. However, recent policy changes may also have had an impact on the percentage of Latinos who are uninsured. For example, 1996 changes in Medicaid eligibility rules made it more difficult for some Latinos to qualify for Medicaid, and changes in immigration statutes may have discouraged some Latinos from applying for public benefits. While racial and ethnic minorities have a greater risk of being uninsured, whites still comprise the majority of the uninsured. The 1999-00 CPS data indicate that 62% of the uninsured were white, compared to 33% of African-Americans and 5% of persons with other racial characteristics.

Younger people are more likely to be uninsured than are older adults. Approximately 29% of adults between the ages of 19 and 24 are uninsured. In contrast, 15.4% of children (18 or younger) are uninsured, and 15% of persons between the ages of 50-64 are uninsured. Adults who have reached the age of 65 have the lowest risk of being uninsured (<1%), as most of them qualify for Medicare. Although young adults have the greatest chance of being uninsured, they are not necessarily the age group with the most unmet health care needs. Generally, the need for health services increases as the population ages.⁹ Thus, in pursuing options to expand

coverage, policy makers may be faced with a choice: either design policies to cover the greatest number of uninsured, or design policies that provide health care coverage to those most in need of health care.

Men are slightly more likely to be uninsured than women. Approximately sixteen percent (15.8%) of men are uninsured, compared to 14.7% of women. Men are generally less likely to qualify for public programs, but more likely to qualify for private employer-based insurance.

Most uninsured are employed. More than two-thirds of the uninsured (68%) are either full-time workers or their dependents; another 8% are part-time workers or their dependents. Only 24% of the uninsured have no connection to the workforce. Workers who are employed in small firms have a much greater risk of being uninsured. Approximately 30% of workers in very small firms (under 10 employees), and 20.5% of the workers in slightly larger firms (10-99 employees), were uninsured according to the 1999-2000 CPS data. The risk of being uninsured drops dramatically for employees of large employers; only 10.1% of the employees of large firms (with more than 1,000 employees) were uninsured.

The reasons that workers are uninsured vary somewhat by size of employer. Small firms are generally less likely to offer health insurance coverage than are larger employers. Nationally, only 60% of the smallest employers (with three to nine employees) offered health insurance coverage in 2000, compared to 79% of employers with 10-24 employees, 87% of employers with 25-49 employees and almost all firms with 50 or more employees.¹⁰ Low-wage workers in small firms are the most likely to be uninsured. In contrast, employees in large firms may lack health insurance coverage because they do not qualify for coverage (e.g., part-time or seasonal employees who work fewer than the required number of hours). In addition, some low-wage workers of large firms may be unable to afford the employee share of premium costs, even if they are offered coverage.

While the risk of being uninsured if the worker is employed by a large firm is small, the actual number of uninsured who work for large firms is sizable. The 1999-2000 CPS data indicate that, of the working uninsured in North Carolina, 170,756 worked for large firms (1,000 or more employees), 131,068 worked for medium sized firms (100-999 employees), 173,186 worked for firms with between 10 and 99 employees, and 219,190 worked for firms

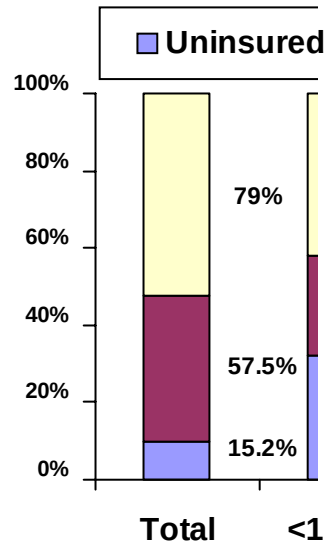


Figure 2. Source of insurance coverage by percent of Federal Poverty Guidelines, North Carolina 1999-2000

with fewer than 10 employees. Thus, while the majority of uninsured employees work in firms of less than 100 employees (56.5%), larger firms also account for a significant number of uninsured workers.

Insurance rates vary not just by size of employer, but also by type of employer. People who work for private households in North Carolina have the greatest risk of being uninsured (61.4%), followed by construction/manufacturing (34.5%) and agriculture (32.3%). Those who work in education (2.9%), public administration (5.0%), wholesale trade (6.8%), and communications (6.7%) had the least risk of being uninsured.

These data suggest that policy efforts aimed at expanding employer-based coverage, such as mandating employer-based health insurance coverage, might significantly reduce the numbers of uninsured. But states are limited in their ability to expand employer-based health insurance coverage by the Employee Retirement and Income Security Act (ERISA), a federal statute that preempts the states' ability to regulate employer health, welfare and pension plans.¹¹

Nationally, most uninsured are uninsured for more than one year. North Carolina does not collect separate data on the length of time that people are uninsured. However, national data suggest that most of the uninsured are uninsured for long periods of time, with 61% being uninsured for 2 years or more and 12% being uninsured for 1-2 years.¹² Only 27% are uninsured for less than one year.

Why are People Uninsured?

While no data exist specific to North Carolina, studies show that most people nationally are uninsured because they cannot afford health insurance. North Carolina experienced

a 13.5% increase in the average cost of employee health benefits in 2001, and this is expected to continue in 2002.¹³ In a 2000 Kaiser/Lehrer study of the uninsured,¹⁴ 47% reported that the primary reason that they lacked health insurance coverage was that they could not afford it. Another 15% reported that their job does not offer health insurance, 15% reported that they were between jobs or unemployed, 5% reported that they could not get or were refused coverage, and 15% reported various other reasons for lacking health insurance coverage. Only 3% reported that they were uninsured because they did not think they needed health insurance. With the rising health insurance costs, more people are likely to be priced out of the health insurance market.

Prior State Policy Efforts to Expand Care to the Uninsured

The state has made many strides in expanding care and coverage to the uninsured (See Table 1). Beginning in the mid-to-late 1980s, the state began expanding Medicaid to cover more low-income pregnant women, children, elderly and disabled. From State Fiscal Year 1987 to 2000, Medicaid grew from 452,025 people to 1,221,266—an increase of 170%. In 1998, the General Assembly created the NC Health Choice program to cover uninsured children with family incomes below 200% of the federal poverty guidelines. The state's efforts to expand coverage to the uninsured continued this year (2001), even in one of the worst budget crisis situations in the state's history. The 2001 General Assembly expanded NC Health Choice and also expanded Medicaid to cover certain low-income women diagnosed with breast or cervical cancer. Without these expansions, the numbers of uninsured would likely have been much higher.

In addition to publicly-financed insurance options, the state tried to make it easier to buy private insurance easier. For example, the General Assembly helped make health insurance more portable by limiting exclusionary periods for people with pre-existing medical conditions and by prohibiting insurance companies from examining the health status of individuals in larger groups before offering insurance coverage. The General Assembly helped expand access to health care providers in medically underserved areas.

State Policy Options to Expand Care to the Uninsured

While the state has taken significant steps to expand or maintain health insurance coverage to more North Carolinians, there are still more than one million people in this state who lack health insurance coverage. This number is expected to grow with the general downturn in the economy; the Kaiser Family Foundation estimates that every one percentage point rise in the unemployment rate leads to 1.2 million more uninsured nationally, or 0.5% of the non-elderly.¹⁵

Between March 2000 and November 2001, North Carolina's unemployment rate rose from 3.4% to 6.1%.¹⁶ If the impact of the rising unemployment rate is the same in North Carolina as nationally, then there may be an additional 90,000 uninsured in North Carolina since the 2000 Current Population Survey (from which the data in this report are derived). Without health insurance coverage, these individuals may be unable to obtain necessary care.

The state has many options to expand coverage to the uninsured. Generally, these fall into four categories: public programs, public-private partnerships, private tax options, or expansion of safety-net programs. There are few options that, by themselves, would ensure that all North Carolinians have coverage. In the absence of a plan for universal coverage, most incremental approaches usually target subgroups of the uninsured. Employment-based insurance options, for example, help only those with connections to the workforce. Similarly, options to expand care to uninsured children would not benefit older adults. Options to expand health insurance coverage to low- or moderate-income individuals may not help those with higher incomes, and *vice versa*. The following is a brief description of some of the options available to the state to expand care to the uninsured. These options are not exhaustive, nor are they mutually exclusive.

Public Programs

North Carolina currently provides health benefits to many low-income individuals through existing public programs. The two largest state-operated programs are Medicaid and NC Health Choice, North Carolina's State Child Health Insurance Plan (SCHIP). In State Fiscal Year 2000, there were 1,221,266 people covered by Medicaid, and 74,145 children covered by NC Health Choice.¹⁷ The state has some options to expand these public programs to cover additional uninsured North Carolinians. Expanding existing public programs has the advantage of building on an existing administrative structure. Moreover, expanding Medicaid has the additional benefit of drawing down federal funds, as the federal government contributes approximately \$0.62 for every \$1.00 in program costs.¹⁸ While additional federal funds are available for Medicaid expansions, other public expansion options would not provide the same uncapped federal match. Nonetheless, the state could create new public programs with 100% state funds.

Medicaid expansion options. States have some flexibility in designing their Medicaid programs within parameters established by the federal government. Federal Medicaid eligibility rules are complex, and have two major restrictions that prevent states from covering all low-income uninsured individuals: categorical eligibility restrictions and income limits. To receive federal Medicaid funds, states must follow federally defined limits ("categorical" restrictions) on the "types" of

Table 1. Past efforts to expand health insurance coverage

The North Carolina General Assembly has established various legislative study commissions over the last 16 years to study the issue and propose methods to expand access to health insurance coverage:

1985-1989	Indigent Health Care Study Commission
1991-1993	Access to Health Insurance Study Commission
1993-1995	NC Health Planning Commission (which was later renamed the NC Health Reform Commission)
1999-1999	Health Care Oversight Legislative Study Commission

In response to these efforts, federal mandates, and interest of key legislators, the North Carolina General Assembly took many steps to expand access to affordable and quality health care. Some of the highlights include:

Expansion of Medicaid coverage to

1987	pregnant women and infants up to 100% of the federal poverty guidelines (effective 1990 up to 185%).
1988	19 - and 20-year-olds
1990	children between ages 1-5 with incomes up to 133% of the federal poverty guidelines
1991	children between the ages of 6-18 with incomes up to 100% of the federal poverty guidelines (began phasing in July 1, 1991, covered all children through age 18 beginning July 1, 1994).
1995	all SSI recipients
1999	the aged, blind and disabled up to 100% of the federal poverty guidelines
2002	uninsured women diagnosed with breast or cervical cancer

Development of new public programs:

1993	Appropriated money to expand the BCBS Caring Program for Children to provide low-cost health insurance coverage to uninsured children
1998	Created NC Health Choice to cover uninsured children with incomes up to 200% of the federal poverty guidelines. Children who are eligible for Medicaid or covered by private health insurance are ineligible for NC Health Choice.
2001	Expanded NC Health Choice to cover more uninsured children and eliminated the two-month waiting period

Insurance reform:

1990	Prohibited medical underwriting in the large group market (50 or more employees)
1992	Small group health reform (guarantee-to-issue two products in the small group market)
1992	Limited pre-existing condition exclusions, made health insurance more portable (effective Jan. 1, 1992 for small group, Jan. 1, 1994 for other groups, July 1, 1995 to cover individual, July 1, 1997 in implementation of federal HIPAA legislation)
1995	Adjusted community rating for small groups (effective Jan. 1, 1995)
1996	Created small group purchasing alliances (enacted July 1993, effective Jan. 1996, repealed December 31, 2000)
1997, 1998, 2001	Managed care reform providing greater consumer protections for individuals enrolled in HMOs, PPOs and POS plans
1991, 1993, 1994, 1995, 1997, 2001	Mandated benefits (covering mammograms, pap smears, PSAs, diabetes education and treatment, drugs to treat cancer, breast reconstruction surgery, and minimum lengths of stay for births and mastectomies, clinical trials)

Expanding access in medically underserved areas:

1993	Directed medical schools to produce more primary care providers
1995	Appropriated \$800,000 to the Office of Rural Health to develop new and expand existing rural health clinics
??	Gave Office of Rural Health greater flexibility to use state funds in recruiting providers to medically underserved areas

individuals covered. For example, states can only provide coverage to pregnant women, children under age 21, parents in families with dependent children, adults aged 65 and older, or disabled individuals who meet the Social Security definition of disability. Coverage of individuals outside the specified groups would require changes to federal Medicaid laws, waivers of traditional Medicaid rules,¹⁹ or the use of entirely state and local funds to pay for expanded coverage.²⁰ Thus, without a waiver, under existing federal Medicaid laws, the state cannot cover poor uninsured adults age 22–64, unless they are disabled or have young children.

States have a little more leeway in setting income and resource eligibility requirements. For example, states can set the income thresholds at the FPG (or higher) for most categories of eligible individuals. North Carolina's current Medicaid eligibility requirements are described in Table 2. States could cover more uninsured through Medicaid by expanding the income guidelines for certain types of people.

North Carolina currently covers parents of Medicaid-eligible children only if the family has an income of about half of the FPG; in 2000, the maximum income allowed to qualify was \$753 per month for a family of four, or approximately 53% FPG.²¹ The income guidelines are the same as those used to determine eligibility for Temporary Aid for Needy Families (TANF). The state has some flexibility in increasing the income limits for working parents.²² There are 15 states that currently offer Medicaid coverage to parents with incomes between 100% and 200% FPG.²³

States also can expand coverage to more uninsured children by expanding Medicaid. In 1997, Congress enacted the State Child Health Insurance Program (SCHIP) to cover uninsured children. States were given three options: to expand Medicaid, create their own state-run program, or create a program that combines Medicaid with a separate state program. North Carolina chose to create a separate state program (called NC Health Choice), administered jointly by the state Medicaid agency and the NC Teachers' and State Employees' Health Plan. Unlike Medicaid, which is an entitlement program—which means that the federal government will continue to contribute its share of program costs to cover all eligibles—the SCHIP program is a block grant. This means the federal government will only contribute a fixed amount of money regardless of the number eligible. For this reason, the state chose to limit the number of children it would cover. North Carolina has been so successful in covering uninsured children in this program that it quickly reached the state's cap. Between January and July 2001, the state stopped enrolling new eligibles. North Carolina could effectively eliminate this cap by increasing the Medicaid income guidelines for the poorest uninsured children under NC Health Choice. These children would then be covered by Medicaid (with open-ended federal contributions), leaving SCHIP federal funds available to cover uninsured children with higher incomes. While this option would increase

the number of children covered by health insurance, it would also increase the costs to the state government.

State-sponsored universal coverage plan. Another way to ensure that all uninsured have access to basic, affordable health insurance coverage would be to provide a basic health insurance plan to all North Carolinians. The model could be financed through taxes, such as a payroll tax on employers and employees, or taxes on goods and services.²⁴ North Carolinians could be enrolled in the NC Teachers' and State Employees' health plan, or in a newly created public-private insurance plan. The state could seek a waiver of federal Medicaid and Medicare laws to enroll individuals currently covered by these programs into the new universal coverage program. A similar model is used in other countries.

While universal coverage plans would ensure that all North Carolinians have health insurance coverage, they may also create the problem of migration of unhealthy persons to North Carolina to obtain health insurance unless similar plans were implemented in other states. To some extent, this problem could also arise if the state implemented any of the other options described in this paper.

Public-Private Partnerships

Public-private partnerships help people purchase private commercial insurance products with the assistance of public funds or programs. Since these programs must be funded solely with state funds, they may have higher costs to the state than programs that are financed by a combination of state, federal and/or local funds. However, these partnerships often give the participants more choice of health insurance plans.

High risk pools. Despite reforms to the group insurance market that took place with the implementation of the Health Insurance Portability and Accountability Act (HIPAA), many people still cannot get health insurance. Individuals with preexisting medical conditions who try to purchase health insurance in the non-group market may be denied coverage or charged prohibitively high premiums. One approach that many states have taken to address the needs of this group of uninsured is to implement a high-risk insurance pool. There are high-risk pools operating in 29 states.²⁵ In 1997, only seven of these pools had enrollments of over 2,000, as the implementation of small group reforms in the early 1990s allowed many high-risk enrollees to purchase coverage in the open market.²⁶

High-risk pools are offered to people who would otherwise go without insurance, by permitting them to purchase coverage similar to that available on the private market at rates that are usually between 135% and 175% of the premium for a healthy person. Some states' risk pools have premiums up to or above 200% of the private market

Table 2. North Carolina Medicaid eligibility requirements (2001)

Group	Income/Resource Limits	Family Size			
		1	2	3	4
Pregnant women and children under age 1	Income: 185% FPG Resource: None	\$1,325/mo	\$1,790/mo	\$2,256/mo	\$2,722/mo
Children age 1 to age 5	Income: 133% FPG Resource: None	\$955/mo	\$1,290/mo	\$1,626/mo	\$1,961/mo
Children age 6 to age 19	Income: 100% FPG Resource: None	\$716/mo	\$968/mo	\$1,220/mo	\$1,471/mo
Children age 19 to age 20	Income: Related to TANF payment amount. Currently approximately 53% FPG, but varies with family size Resource:	\$362/mo \$3,000	\$472/mo \$3,000	\$544/mo \$3,000	\$594/mo \$3,000
Caretaker relative: persons (usually parents) who live with relatives under age 19	Income: Related to TANF payment amount. Currently approximately 53% FPG., but varies with family size Resource :	\$362/mo \$3,000	\$472/mo \$3,000	\$544/mo \$3,000	\$594/mo \$3,000
Aged (over 65), blind or disabled by Social Security standards	Income: 100% FPG Resource:	\$716/mo \$2,000	\$968/mo \$3,000		
Medicare beneficiaries persons who have Medicare Part A; Medicaid pays for Medicare premiums, deductibles, and co-payments	Income: 100% FPG Resource:	\$716/mo \$4,000	\$968/mo \$6,000		
Medicaid pays Medicare Part B premiums only	Income: 120% FPG Resource:	\$859/mo \$4,000	\$1,161/mo \$6,000		
Deductible/ spenddown persons who do not meet the income limits specified above and who have high medical bills may be eligible for Medicaid after meeting a deductible. The deductible is based on how much the monthly income exceeds this income limit:	Income: 35% FPG	\$242/mo	\$317/mo	\$367/mo	\$400/mo
Families & children	Resource:	\$3,000	\$3,000	\$3,000	\$3,000
Aged, blind, disabled	Resource:	\$2,000	\$3,000		

premium for a healthy person. Since the medical costs of the high-risk individuals often exceed even the increased premiums, the additional costs are funded through methods such as general state funds or taxes on hospitals or health insurance companies.²⁷ High-risk pools often have strict eligibility requirements, such as proof of denial of coverage from two insurance companies, or proof of premium estimates above the cost of coverage provided through the risk pool. In addition, most risk pools have waiting periods for pre-existing conditions to prevent people from going without coverage until they become sick. The Government Accounting Office found that premiums for certain people in poor health were significantly less in states with high-risk pools than in states without such plans.²⁸

North Carolina currently operates a high-risk pool though Blue Cross-Blue Shield of North Carolina. The program, Access, is available to people who have lived in North Carolina for at least six months and have no other coverage available to them. As of January 2002, 85 people were enrolled in the Access program. While the rates for Access are significantly higher than Blue Cross-Blue Shield's regular portfolio of products, the program does offer protection for those with serious medical conditions.²⁹

Coverage for workers between jobs. Health insurance is strongly tied to employment in this country. People are far more likely to be uninsured if they are unemployed than if they work full-time.³⁰ Nationally, there are twice as many uninsured heads of households who are unemployed than who work full-time. Federal laws (derived from COBRA, the Consolidated Budget and Reconciliation Act) permit certain people who lose their employer-based health insurance coverage (for example, when they lose their job or divorce the covered employee) to continue this coverage through the firm's group policy for a certain length of time.³¹ The premiums are the same as when the employee was employed; however, the individual must pay the full premium costs (i.e., the employer has no obligation to make premium contributions). Combined with the additional economic burden of being unemployed, COBRA coverage is often prohibitively expensive for unemployed workers. Subsidizing COBRA for the low- and moderate-income unemployed could assist these families in maintaining health insurance coverage.

Subsidies could be administered through existing unemployment and welfare offices and could vary with income.³² For example, families with incomes below 200% FPG could receive 90% of COBRA premiums with subsidies declining up to incomes of 300% FPG. In addition, to make program administration most efficient, subsidies would have to extend over the same duration as current unemployment benefits, i.e., six months. Exact figures are not known for the number of uninsured, unemployed workers with incomes below 300% FPG. However, the Kaiser Family Foundation reported that only 3% of all uninsured in the country are

workers with incomes less than 240% FPG who have been unemployed for less than 6 months and who were previously employed by a firm offering health insurance.

Health insurance vouchers for low-income adults and families. In 2000, there were approximately 309,000 uninsured North Carolinians with incomes between 100% and 200% FPG.³³ Nationally, approximately 79% of families in this income range have at least one full-time worker.³⁴ Workers with low wages are less likely than their higher wage counterparts to be employed by firms offering health insurance. Those low-wage workers who do have access to employer-sponsored coverage are less likely than other workers to accept health benefits. The most common reason for not participating in employer-sponsored health insurance is premium cost.³⁵

The state could consider offering a voucher to help subsidize the employee share of employer-based health insurance for low-wage workers. The Health Insurance Association of America (HIAA) proposed that government provide a voucher equal to approximately \$2000, or about 75% of the average premium under the Federal Employee Health Benefit Plan to those with incomes between 100-200% of the federal poverty guidelines.³⁶ HIAA estimates that under this proposal between 75% and 90% of those eligible would obtain coverage.³⁷ The costs of such a proposal would be dependent on whether the voucher was offered to the 1.4 million North Carolinians with incomes between 100-200% of the federal poverty guidelines, or only the approximately 309,000 who are uninsured.

Tax Credits or Deductions

Like public-private partnerships, approaches based on tax credits or deductions rely heavily on the private health insurance market. These approaches are appealing for several reasons. It is sometimes easier to gain support for tax-based reforms than for reforms that would require significant appropriations for new programs.³⁸ In addition, the administrative system needed to administer tax-based reforms is already in place. Despite their advantages, tax-based reforms can be as difficult to design as other approaches. Different program designs have different outcomes, in terms of populations targeted and the number of participants.³⁹

The most significant option in tax reform proposals is whether the program is launched as a tax deduction or a tax credit. The monetary value of a tax deduction depends on a family's income and is therefore regressive in comparison to a tax credit. The higher a family's income and tax bracket, the larger the dollar value of the deduction. For example, a tax deduction of \$1,000 would be worth almost \$400 to a family in the highest tax bracket, while to a family in the 15% tax bracket it would be worth only \$150. In addition, many families who are uninsured do not have enough income to be required to pay any taxes. Many existing tax deductions are

also limited to the 29% of taxpayers who itemize their tax returns. However, it would be possible to design a deduction that could be taken regardless of whether or not a family chooses to itemize.

While tax deductions are regressive, they are relatively easy to administer. Tax credits, on the other hand, offer more options, but may require a more complicated administrative system. Tax credits can be refundable, which means that they can be provided to families who are not required to pay taxes or who owe less taxes than the potential refund. They can also be paid in advance or on a periodic basis. In addition, the amount of the credit can vary depending on the amount of insurance purchased or the family's income. The type of credit implemented will likely affect the number of uninsured who participate and the administrative complexity of the program. For example, more people are likely to use a refundable tax credit than one that only covers the amount of the families' tax burden. Some families may be unable or unwilling to purchase coverage if the tax credit does not come until the end of the year. Providing a tax credit that is paid in advance can help alleviate this problem. Still, some families may be concerned that if they take the credit in advance and end up not purchasing coverage or purchasing coverage that costs less than the credit, then they will owe the government money at the end of the year. Furthermore, if the tax credit is capped at a certain amount, families may be reluctant to purchase more comprehensive plans; yet, if the credit is not capped, families may be encouraged to purchase plans that offer unnecessary benefits and are inefficient.

Most tax reform approaches to expanding coverage are more effective on the federal level than on the state level. Since state tax rates are lower than federal tax rates, many taxpayers do not pay enough state taxes to make a state level deduction or non-refundable credit a significant value.

Tax credit for small employers. Employees of small firms are more likely than those of large firms to be uninsured, in part because small employers are less likely to offer group health insurance to their employees.⁴⁰ The primary reasons small employers do not offer health insurance to their employees are high premium costs and insufficient profits.⁴¹ In addition, as a group, employees of small firms earn less than those in larger firms.⁴² Even when offered insurance, low-wage employees may be unable to afford the premiums, and thus are less likely than higher-wage employees to elect coverage.⁴³

One method for decreasing the employers' costs of providing health benefits is to subsidize the cost of insurance premiums with an employer tax credit. In a 1989 study of New York firms with 20 or fewer employees that did not offer health insurance, 56% of surveyed firms indicated that they would be somewhat or very likely to purchase health insurance for their employees if the premium cost was 50% subsidized. Seventy-six percent of the surveyed firms were somewhat or very likely to purchase insurance if it was 75%

subsidized. Despite the promising results of the survey, in practice few small employers actually used tax subsidies to offer coverage. Participation rates depend on small employers' awareness of the program and the eligibility requirements for participation in the program.⁴⁴ States that offer subsidized insurance, not necessarily through tax credits, have seen the number of uninsured firms that began to offer health insurance increase between 2.5% and 16.3%. In order to make premiums more affordable to lower-wage workers in small firms, the tax subsidy could be limited to those employers that contribute a certain percentage (e.g., 80% or more) toward the premium cost.

Medical Savings Accounts: Medical Savings Accounts (MSAs) are high deductible health insurance policies combined with pre-tax medical IRAs. Individuals and/or their employers pay the premium costs of a high-deductible health insurance policy (generally much less expensive than traditional insurance plans), and make tax-free contributions into the medical IRA. Funds can be withdrawn from the medical IRA to pay for health care costs to meet the deductible. Since the decision regarding what services and procedures to pay for would be up to the consumer, MSAs are thought to be a good mechanism for controlling health care costs. Consumers would be aware of the full cost of their medical care and they would be responsible for paying for their care from the funds available in their MSA. However, concerns have been raised about whether MSAs mainly will attract the healthy and wealthy, leaving those who are sicker in traditional health insurance pools. This, in turn, could raise the health insurance costs for individuals who are most in need.

Federal law allows two groups of people to establish Medical Savings Accounts with pre-tax dollars: individuals who work for firms with under 50 employees, and Medicare recipients. Theoretically, MSAs could be a viable option for employees of small companies. However, in practice, there are few insurers selling MSAs to the small group market in North Carolina.⁴⁵ States could establish tax deductibility for MSAs, but the amount of state tax deductions may not be sufficient to enable lower-income individuals to afford these policies.

Expanded premium deductibility for individuals without access to employer sponsored coverage. Under current laws, only individuals with employer-sponsored health insurance and the self-employed have access to federal tax-based premium subsidies. The Health Insurance Portability and Accountability Act (HIPAA) included an expansion of deductions for the self-employed to 80% by 2006—meaning that they will be able to exclude 80% of premium costs from their taxable income. The Balanced Budget Act (BBA) of 1997 expanded this deduction to 100% of premium costs.⁴⁶ This policy leaves the uninsured and people who purchase insurance on the individual market without premium subsidies.

Currently, these two groups account for almost 1.5 million North Carolinians.⁴⁷ In order to permit all people with insurance to have access to equal premium subsidies, the Kaiser Family Foundation explored the option of allowing all people purchasing insurance who do not have access to employer sponsored coverage to be permitted to deduct 80% of their premium cost from their taxable income.⁴⁸

Under the 80% premium deduction, national estimates suggest that about 1% of non-elderly uninsured adults would become covered and about 2% of uninsured children would become covered.⁴⁹ In North Carolina this would equal approximately 8,700 newly covered adults and 5,200 newly covered children.⁵⁰ While the actual cost of the program per enrollee depends on premium cost and enrollee's tax bracket, it is estimated that the average cost per enrollee (the value of the lost tax revenue) would be approximately \$265.⁵¹ This small subsidy may be helpful to families who already purchase insurance policies, but may be insufficient to encourage many of the uninsured to purchase insurance.

Delivery System Options

While many options to expand care for the uninsured are based on providing health insurance coverage to the uninsured, other systems could be designed to ensure that the uninsured have access to some services in the absence of insurance coverage. Delivery system models expand funding for "safety-net" providers to allow them to cover the cost of caring for more uninsured. These models can range from more limited options that provide primary care services to those that need care and might not otherwise be able to afford it, to more comprehensive integrated systems that provide all levels of care.

Expanding the capacity of safety-net providers to care for the uninsured. North Carolina's health care safety-net providers are an important part of care for the state's uninsured population. They include the state's Migrant and Community Health Centers in 62 clinical sites; 31 state-funded Rural Health Clinics; 33 private, not-for-profit free clinics;⁵² 35 health departments,⁵³ 53 school-based or school-linked health centers in 27 counties, and other providers that provide comprehensive primary care services to the uninsured for free or on a sliding-scale basis. According to the North Carolina Primary Health Care Association, for example, approximately 44% of the 223,729 patients that were seen at Community Health Centers in 2000 did not have insurance.⁵⁴ In addition to the safety-net providers that provide primary care, hospitals also provide care to the uninsured.

These providers exist primarily to serve the uninsured and often receive state or federal funds that require them to serve the uninsured in addition to other populations. Some of these clinics and hospitals have historically used revenue from other patients, such as Medicaid recipients, to offset

some of the costs associated with caring for the uninsured. However, increased managed care penetration has made Medicaid patients more attractive to providers not traditionally serving that population. The consequent loss of Medicaid patients and revenues has left some safety net providers with fewer resources available for uninsured patients. Other providers, such as free clinics, are operated by volunteers and therefore have limited capacity to see uninsured patients.⁵⁵ Increasing state funding of North Carolina's safety net providers will give them the financial means to provide primary care to more of the state's uninsured. However, this approach is not a complete substitute for health insurance since it fails to cover specialty care or hospitalizations.

*Project Access expansion (Buncombe County Medical Society model):*⁵⁶ The not-for-profit free clinics currently operating in the state are typically open one or two nights a week and serve primarily uninsured and low-income patients. Many provide primary care, but offer few specialty services and may have limited capacity to provide pharmaceuticals. Buncombe County Medical Society's Project Access (described in a separate article in this issue) is a comprehensive and coordinated care delivery system that provides free health services to uninsured Buncombe County residents with family incomes at or below 200% FPG. Eligible individuals are enrolled at one of several primary care clinics and, if necessary, are referred to specialty physicians or pharmacies. If appropriate, they may also be referred to one of Buncombe County's hospitals.

All physician services and hospital care are donated by the county's physicians and hospitals. Start-up funding for the program came from the Robert Wood Johnson Foundation and the Kate B. Reynolds Charitable Trust. Buncombe County contributes \$250,000 toward the cost of pharmaceutical care. This is money the county was contributing to Mission Memorial Hospital to support care of the uninsured, so no new appropriation was needed. In addition, the health department had a pre-existing project that helped low income people pay for prescription drugs. Some pharmaceutical companies also provide free medications to uninsured individuals who meet certain eligibility requirements (which vary by company). Project Access tracks all services provided by filing dummy claims with Mountain Health Care, a local for-profit Independent Practice Association that provides this service free of charge. During 1998, Project Access enrolled and provided care to approximately 13,000 of Buncombe County's estimated 15,000 low-income uninsured. Similar programs have been started in Guilford, Moore, Onslow, Pitt, Watagua, and Wake counties.

Expanding programs like Project Access would require support and funding from medical societies, hospitals, other health care providers, and claims processing organizations. In addition, depending on other community support, some funding may be necessary from government and/or private

foundations. Expansion of the Project Access model is limited to communities where providers are willing and able to donate time and resources to cover care for the uninsured, and communities where leadership has emerged from within the local private medical or hospital community. The Project Access model may not work as well in rural communities with few providers. Pharmaceutical costs also would be much higher in communities without established programs to pay for prescription drugs, which would necessitate foundation or governmental support. Foundation and/or governmental funds may be needed to pay for medicines, administrative, and other non-donated health care costs.

Conclusion

This paper provides an overview of the number and characteristics of the uninsured in North Carolina, and describes different ways to expand coverage and access to health care

for the uninsured. Only one of the proposals—providing coverage through the NC Teachers' and State Employees' Health Plan or other public-private partnership—would provide universal coverage to all North Carolinians. The other possible approaches would be incremental. Some incremental approaches are better suited to particular populations. For example, public programs or direct subsidies to purchase health insurance will be more effective than tax subsidies for low-income populations. On the other hand, tax subsidies may be more effective for small employers or higher income working populations. Depending on the target population, different approaches may be needed.

However North Carolina responds to this set of issues, the direct and indirect impact of such a large and increasing number of uninsured is substantial. Providing appropriate health care coverage for this growing population should be among our state's highest priorities as we seek to improve the health of all North Carolinians.

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- 2 Kaiser Family Foundation. The Uninsured: A Primer. March 2001. Available online: <http://www.kff.org/content/2001/2228/>.
- 3 Uninsured in America: A Chart Book. Kaiser Commission on Medicaid and the Uninsured. May 2000. pp. 56, 67.
- 4 Asking respondents directly whether they were uninsured reduced the total numbers of uninsured by 8%. Because the authors were using two year averages to determine the numbers of uninsured, and the 2000 revised estimates were not completed until after the analysis was completed, the authors used unadjusted 2000 CPS numbers.
- 5 Lewis K, Ellwood M, Czajka JL. Counting the Uninsured: A Review of the Literature. Urban Institute. June 1998.
- 6 The data were taken from the March supplement to the Current Population Survey (CPS). Each March, the US Census Bureau collects national data on health insurance coverage. Respondents are asked the following question: "At any time in 199X, (were you/was anyone in this household) covered by a health plan provided through (your/their) current or former employer or union?" The same question is asked about Medicaid, Medicare, Champus, and other private insurance. Respondents who report no other source of coverage are listed as uninsured. While respondents are asked if they had health insurance coverage *at any time* during the past year, most experts suggest that the responses more closely reflect if the respondent had insurance *at that moment* when the question was asked. (Lewis K, Ellwood M, Czajka JL. Counting the Uninsured: A Review of the Literature. Urban Institute. June 1998). Thus, the CPS data reflects the numbers of uninsured on any given day.
- 7 The Census surveyed approximately 3,200 people in North Carolina in 1998 and 1999 (1999 and 2000 March Current Population Surveys, US Census Bureau). To ensure meaningful data for the state, two years of data were combined and analyzed.
- 8 The CPS historically undercounts Medicaid eligibles. This potential undercounting of Medicaid eligibles may inflate the numbers of uninsured, since the calculation of the numbers of uninsured is based on the number of people who stated they have had no other source of health insurance coverage. (Lewis K, Ellwood M, Czajka JL. Counting the Uninsured: A Review of the Literature. Urban Institute. June 1998). The data have not been adjusted to reflect actual NC Medicaid eligibles.
- 9 Cunningham PJ. Next Steps in Incremental Health Insurance Expansions: Who is Most Deserving? Center for Studying Health System Change. April 1998, No. 12. <http://www.hschange.org/CONTENT/69/issue12a.html>. "Young adults age 19-24 have the highest uninsurance rates... followed by those age 25 to 34... In contrast, less than 10% of near-elderly individuals are uninsured... While older adults have relatively low rates of uninsurance, those who are uninsured may have the most difficulty obtaining insurance coverage as they approach the age of Medicare eligibility." It often costs older adults more to purchase health insurance. "Since older adults generally are higher health risks, the cost of purchasing coverage will be significantly greater for them than for other age groups." Policy makers need to consider the goal of incremental coverage before deciding which group(s) to target. "If the goal is to reduce the numbers of uninsured persons, then targeting young adults would be most effective, not only because of the high rate of uninsurance among this group, but also because they are less expensive to cover... If the goal is to target assistance to those with significant health care needs, then there is some justification for focusing on the near-elderly..."
- 10 Gabel J, Levitt L, Pickreign J, et. al. Job-Based Health Insurance in 2000: Premiums Rise Sharply While Coverage Grows. Health Affairs. Sept/Oct 2000;19(5):144-151.
- 11 Butler P. Roadblock to Reform: ERISA Implications for State Health Care Initiatives. National Governors Association. 1994.

- 12 Uninsured in America: A Chart Book. Kaiser Commission on Medicaid and Uninsured. May 2000. Citing: The News Hour with Jim Lehrer/Kaiser Family Foundation Survey on Uninsured 2000.
- 13 Fisher JP. NC Leads South's Rising Health Costs. News and Observer. December 10, 2001 on p. 1A.
- 14 Uninsured in America: A Chart Book. Kaiser Commission on Medicaid and Uninsured. May 2000, citing The NewsHour with Jim Lehrer/Kaiser Family Foundation, National Survey on the Uninsured 2000.
- 15 Gruber J, Levitt L. Rising Unemployment and the Uninsured. Kaiser Family Foundation. December 2001. Available online at: <http://www.kff.org/content/2001/6011/>. The report also notes that the increase in the numbers of people without health insurance would likely be much greater if states restrict the numbers of people who would otherwise qualify for Medicaid.
- 16 Employment Security Commission. Information on monthly unemployment rates available on-line at: <http://www.esc.state.nc.us/>.
- 17 Medicaid numbers cover state fiscal year 2000 and are from: "North Carolina Medicaid State Fiscal Years 1979-2000 A History of Medicaid Eligibles." North Carolina Department of Health and Human Services. Division of Medical Assistance. Available online: <http://www.dhhs.state.nc.us/dma/2000report/table9.pdf>. NC Health Choice enrollment numbers are for September 2000 and are from: "Framework for Annual Report of State Children's Health Insurance Plans under Title XXI of the Social Security Act: North Carolina." North Carolina Department of Health and Human Services. Division of Medical Assistance. Available online: <http://www.dhhs.state.nc.us/dma/>.
- 18 The federal government paid 62.49% of program costs in Federal Fiscal Year 2000. The state paid 31.88% and the counties paid 5.63%. NC Division of Medical Assistance. Table 1. North Carolina Medicaid State Fiscal Year 2000 Federal Matching Rates. Available on the internet at: <http://www.dhhs.state.nc.us/dma/2000report/table1.pdf>.
- 19 The Health Care Financing Administration (HCFA) can authorize a waiver of Medicaid program requirements under 1115 demonstration waivers. To obtain a waiver, a state must show that the program will be cost neutral. Thirteen states in the past have obtained 1115 waivers, and used savings obtained by enrolling Medicaid recipients into managed care to expand Medicaid coverage to previously uninsured groups. (Health Care Financing Administration. States with Comprehensive Health Care Reform Demonstrations, Dec. 31, 1999. Available online: <http://www.hcfa.gov/medicaid/11151299.htm>). Recent experience has shown that the estimated savings from managed care have not been as great as anticipated, making it difficult to continue coverage for these uninsured groups. (Holahan, John et al. "Health Policy for the Low-Income Population: Major Findings from the Assessing the New Federalism Case Studies." Urban Institute. June 1999. Available online: <http://newfederalism.urban.org/html/occa26.html>).
- 20 Several states have implemented state-funded health insurance programs for the uninsured, including Minnesota and Washington states. Lipson D. (State-Subsidized Insurance Programs for Low Income People. State Initiatives in Health Care. Alpha Center. 1996).
- 21 "NC DMA Financial Eligibility Fact Sheet." North Carolina Department of Health and Human Services. Division of Medical Assistance. March 2000.
- 22 Guyer J, Mann C. "Taking the Next Step: States Can Now Expand Health Coverage to Low-Income Working Parents Through Medicaid." Center for Budget and Policy Priorities. August 1998. Available online: www.cbpp.org.
- 23 "Disparities in Eligibility for Public Health Insurance between Children and Adults in 2000." Families USA. March 2000. Available online: www.familiesusa.org.
- 24 A study by Lewin-VHI for the North Carolina Health Planning Commission in 1994 estimated the costs of a similar tax-based universal coverage model. North Carolina Health Planning Commission. Final Report of the Financing Advisory Committee. Appendix B. December 1994. The plan included coverage of inpatient hospitalizations, outpatient services, physician services, preventive care, subacute care, prescription drugs, inpatient and outpatient mental health services. The cost of coverage for workers and dependents would have been financed through a payroll tax of 6.73% for employers, and 1.69% for employees. Overall, this plan was estimated to save \$1.1 billion in health care costs in North Carolina (because of large savings in administrative costs); although the costs to particular individuals and employers could increase or decrease depending on the amounts previously paid. This model would be particularly costly to firms that do not currently provide (and to individuals that do not currently pay) for health insurance coverage. Presumably, for employers and individuals that currently pay for health insurance coverage, the payroll tax would substitute for existing premium payments. To avoid potential ERISA problems, employers would still be free to offer supplemental (or duplicate) health insurance coverage to their employees. The net cost of this plan to employers that currently offer health insurance coverage would depend on whether an employer chose to supplement the tax-based health insurance coverage offered to all North Carolinians.
- 25 "Private Health Insurance: Progress and Challenges in Implementing 1996 Federal Standards." United States General Accounting Office. May 1999. p. 3. Available online: www.gao.gov; more recent information available at: Communicating for Agriculture and the Self-Employed. Available online at: <http://www.cainc.org/riskpools.html>.
- 26 "The Individual Insurance Market: Performance and Potential." AHCPR. May 1999. Available Online: www.ahrq.gov.
- 27 "Risk Pools." Communicating for Agriculture. Available Online: www.cainc.org.
- 28 "Private Health Insurance: Progress and Challenges in Implementing 1996 Federal Standards." United States General Accounting Office (GAO). May 1999. GAO/HEHS-99-100. Available online at: www.gao.gov. The Health Insurance Portability and Accountability Act (HIPAA) requires health insurers to offer health insurance to certain eligible individuals with pre-existing conditions. While insurers cannot exclude coverage to these individuals, there is no limit on how much may be charged. GAO found that in states without a high-risk pool, individuals may pay premiums that were between 100-464% of a standard product, whereas the same individual would typically be charged no more than 200% of a standard

- product in a state with a high-risk pool.
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 - 30 "The Difference Different Approaches Make: Comparing Proposals to Expand Health Insurance." The Kaiser Project on Incremental Health Reform. Kaiser Family Foundation. October 1999. p. 20.
 - 31 COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1986) requires employers with 20 or more employees to provide continuation coverage to individuals who: had their hours reduced so they no longer qualify for health insurance coverage; have been fired or quit a job; or lose employer-based health insurance due to divorce, legal separation, or the death of a covered employee. Children who age out of dependent coverage may also qualify. North Carolina has a similar law that covers employers with fewer than 20 employees. Silberman P, Wettach JR. A Consumers Guide to Health Insurance and Health Programs in North Carolina. North Carolina Primary Health Care Association. Cary, NC. 1995.
 - 32 Program design information from "The Difference Different Approaches Make." The Kaiser Project on Incremental Health Reform. Kaiser Family Foundation. October 1999. p. 22.
 - 33 US Census Bureau. Current Population Survey, March 1999, 2000. Average from the two years applied to the 2000 North Carolina population estimates from the NC Office of State Planning.
 - 34 "Health Insurance Coverage of Low-Wage Workers." Kaiser Family Foundation. June 1999. Available online: www.kff.org.
 - 35 "Uninsured in America: Key Facts about Gaps in Health Insurance Cover Today." Kaiser Family Foundation. Available online: www.kff.org.
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 - 37 Custer WS. "Estimated Cost and Coverage Impact of the HIAA Proposal to Cover the Uninsured." Health Insurance Association of America. May 17, 1999. Available online: www.insureusa.org.
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 - 39 "Tax Reform to Expand Health Coverage," in *Assessing Tax Subsidies to Cover the Uninsured*. Kaiser Family Foundation. January 2000. p. 5.
 - 40 An employer "offers" health insurance when it gives its employees the opportunity to enroll in an insurance plan at group rates (which is much cheaper than rates for comparable insurance products in the non-group individual market). "Offering" group health insurance does not automatically mean that the employer subsidizes part of the employees' premium cost; although as a practical matter, most employers pay all or part of the employees' premiums.
 - 41 Thorpe K et al. "Reducing the Number of Uninsured by Subsidizing Employment-Based Health Insurance: Results From a Pilot Study." JAMA. February 19, 1992. Vol. 267 (7). pp. 945-948. p. 945.
 - 42 Nichols L et al. "Small Employers: Their Diversity and Health Insurance." Urban Institute. June 1997. Available online: www.urban.org.
 - 43 O'Brien E, Feder J. "Employment-Based Health Insurance Coverage and Its Decline: The Growing Plight of Low-Wage Workers." Kaiser Commission on Medicaid and the Uninsured. May 1999. p. 6. Available online: www.kff.org.
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 - 47 US Census Bureau. Current Population Survey, March 1998, 1999. Average from the two years applied to the 1999 North Carolina population estimates from the NC Office of State Planning. Estimate based on approximately 1.1 million uninsured and 340,000 privately insured.
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 - 49 Feder J et al. "The Difference Different Approaches Make: Comparing Proposals to Expand Health Insurance." The Kaiser Project on Incremental Health Reform. Kaiser Family Foundation. October 1999. p. 24. Available online: www.kff.org.
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 - 51 "The Difference Different Approaches Make: Comparing Proposals to Expand Health Insurance." The Kaiser Project on Incremental Health Reform. Kaiser Family Foundation. October 1999. p. 27.
 - 52 Mills J. Personal communication. January 15, 2002.
 - 53 Simms J. Asst. Director for Managed Care, NC Division of Medical Assistance. March 10, 2001. These health departments operate as Carolina Access sites, which mean that they provide full primary care services and their providers are available (on-call) 24 hours/day, 7 days a week. Of these, 10 limit their primary care services to children, and one limits their services to adults.
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 - 55 Mills J. In *Migrant and Community Health Centers, Rural Health Clinics and Free Clinics Operating in North Carolina*. See Appendix D.
 - 56 All information on Buncombe County Medical Society's Project Access from "BCMS Project Access Overview" and "Health Care Access and Health Status of Project Access Patients: Report to the Buncombe County Medical Society, October 1998." BCMS Project Access provided both publications.
 - 57 At the same time, the NC IOM established a Task Force, chaired by William Friday, to develop proposals to expand access to health insurance for the uninsured.