

AHEC Teaching Clinics in Service to the Uninsured

Thomas J. Bacon, DrPH

One of the primary reasons for establishing the North Carolina Area Health Education Centers (AHEC) Program in the early 1970s was to create a statewide infrastructure to expand the training of primary care physicians in the state. With support from the North Carolina General Assembly, AHEC today supports eight residency programs in family medicine, four in internal medicine, four in obstetrics and gynecology, three in pediatrics, and three in surgery. These programs employ 260 full-time faculty and 285 residents, which is nearly 15% of the total number of residents in training in the state.

These AHEC residency programs, in close partnership with their community teaching hospitals, provide a significant amount of safety net care throughout North Carolina. As with teaching programs across the country, the clinics operated by these residencies and teaching hospitals take all patients, regardless of ability to pay. In addition, the teaching services serve as the means to admit patients to hospitals that come through the emergency room and have no regular physician. Frequently, these patients do not have insurance coverage.

During 2003-2004, AHEC teaching services provided more than 450,000 outpatient visits and more than 184,000 inpatient visits of care. Nearly 100,000 of these outpatient visits were for uninsured patients, and more than 36,000 of the inpatient visits were for uninsured patients. AHEC clinics also have high numbers of Medicaid and Medicare patients, and the reimbursement rates of both public programs have not kept up with the rising costs of care.

Beyond their own clinics, AHEC residencies work closely with other safety net providers to create better systems of care. Most work closely with health departments to improve the safety net, including rotating residents to health department clinics, coordinating and in some cases integrating health department and AHEC clinic services, and seeking grants to establish new models of care. In some AHECs, such as Wilmington, faculty

lead outreach clinics in surrounding rural counties to expand access for the uninsured. In Fayetteville, the AHEC hosts the regional child abuse clinic, and supports HIV/AIDS and other outreach clinics in nearby rural counties. AHEC faculty have taken the lead in developing new community-wide safety net programs, such as the role Mountain AHEC faculty played in establishing Project Access in Asheville.

The workforce development role of AHEC residencies is also critical to maintaining and strengthening the safety net services in the state. AHEC residencies were initially established to expand

statewide capacity to train physicians to meet the physician workforce needs of underserved communities. Data from the past 25 years indicate that the AHEC residencies are effectively fulfilling that mission. Over 1,500 residents have graduated from AHEC primary care residen-

cies, and two-thirds of them have remained in North Carolina to practice. In addition, graduates of AHEC residencies are more likely to settle in rural and other underserved communities than graduates of residencies at a university medical center.

As with other safety net providers, AHEC and hospital-based clinics face a number of financial challenges. The number of uninsured patients seeking care continues to grow as employer-based health insurance becomes more expensive and less available. State appropriations for AHEC and other related programs have declined over the last four years, and federal grant support via the Bureau of Health Professions has also declined. At the same time, costs for malpractice premiums, new technology, and recruiting and retaining faculty have all increased.

In spite of the challenges, the AHEC Program remains committed to maintaining and strengthening its statewide network of primary care residencies. As the population of North Carolina continues to grow at a rate faster than the national average, it may be necessary to further expand the number of residency positions to assure that the physician supply for the state remains adequate to meet the growing needs of our population. **NCMJ**

“...AHEC residencies work closely with other safety net providers to create better systems of care.”

Thomas J. Bacon, DrPH, is the Director of the North Carolina AHEC Program. He can be reached at tom.bacon@med.unc.edu or CB# 7165, University of North Carolina at Chapel Hill, Chapel Hill, NC 27599-7165.

Who is at Risk of Losing Safety Net Healthcare?

Adam G. Searing, JD, MPH

Ms. McDaugherty, a 30-year-old widow with two children, works as a waitress. Her job pays enough to put her income slightly above eligibility for the North Carolina Medicaid program (\$11,425 annually), but offers no health insurance coverage. Her earnings of roughly \$1,000 a month are quickly used to pay for rent and utilities for an efficiency apartment (\$700), food (\$150), and public transportation (\$100).

Just as she was starting to get on her feet economically, less than a year after she lost her husband, Ms. McDaugherty found a lump in her breast. Tests performed at a community clinic found that she had a malignant tumor that had already spread to her lymph nodes.

Since her income is slightly above the federal poverty level, she can only qualify for Medicaid as an "optional beneficiary" because she has been diagnosed with breast cancer. Because of Medicaid, Ms. McDaugherty was able to see a specialist who advised her that she needed a lumpectomy, followed by chemotherapy and radiation treatment. The Medicaid program currently covers all of Ms. McDaugherty's cancer treatments, including medications for the side effects of chemotherapy, which help her continue working part-time.

As an "optional beneficiary," she would be one of the first to completely lose health coverage as a result of federal or state budget cuts to Medicaid, since her income is slightly above poverty level. Even if coverage is continued, North Carolina could select a narrow list of services that would be covered for people like her. For example, the state might limit the drugs that help control the side effects of her cancer drugs and allow her to work.ⁱ

Strengthening the Safety Net, Covering the Uninsured, Controlling Health Costs

Three years ago I wrote an article for the *North Carolina Medical Journal* entitled "The Uninsured and Medicaid."¹ I surveyed the Medicaid program and the situation of the uninsured, noted the drivers of rising costs, the necessity of denying healthcare to people currently covered by Medicaid to achieve truly substantial cost savings called for by proposed state budget cuts, and the need for new revenue to sustain the program in a time of economic downturn so that even more people would not join the ranks of the uninsured.

To borrow an apt example from a noted health policy researcher,² Bill Murray in the movie "Groundhog Day" and I have much in common as I address this issue again for the Journal. Medicaid costs continue to increase along with general healthcare costs and as we ask the program to absorb more people who have lost insurance. Substantial budget cuts are proposed by the federal government that could only be covered by denying Medicaid coverage to tens of thousands of North Carolinians.³ Once again, we need to find new revenue in order to address growing health costs and the growing numbers of the uninsured. Finally, there are no detailed plans for reform under consideration by political leaders in North Carolina.

Although the problems are the same today as they were in 2002, they could be much worse. Unlike many states, North Carolina chose to enact incremental tax increases over the last three years so we could maintain state health, education, and other vital services for our residents. While there have been some cuts, we have avoided the examples of states as diverse as Oregon, Texas, and Mississippi, where hundreds of thousands of vulnerable seniors and children have joined the ranks of the uninsured after being cut from Medicaid coverage.

Still, the picture in North Carolina is grim. New reports show that from 2000 to 2003, over 457,000 North Carolinians

ⁱ This example is based on a real person and was developed by FamiliesUSA and the North Carolina Health Access Coalition. See "The Bush Administration's Proposed Structural Changes to Medicaid: Hurting Real North Carolinians," www.familiesusa.org.

Adam G. Searing, JD, MPH, is Project Director for the North Carolina Justice Center's Health Access Coalition and Health Co-Chair for the Covenant with North Carolina's Children. He can be reached at adam@ncjustic.org or PO Box 27167, Raleigh, North Carolina 27611-7167. Telephone: 919-856-2568.

have lost health insurance due to rising health costs and the economic downturn—one of the highest rates in the country.^{4,5} Over 300,000 people have joined the ranks of the uninsured since 2000, and we have added over 230,000 people to Medicaid. Premiums for employer-based plans in North Carolina have risen by 43.4% between 2000 and 2003.⁴ A family health insurance plan in North Carolina now costs about \$9,000 per year.⁵ There are now 1.5 million people on Medicaid in North Carolina and 1.4 million people without health insurance.

When people talk about health reform, they often imagine a magic bullet that will decrease health costs, extend coverage, and not cost any more than we spend right now. Over the last 70 years, no magic bullet has appeared, although many have been proposed. The current crop includes medical malpractice changes, health savings accounts, a single payer health system, and electronic medical records. While each of these ideas probably has some positive aspects, none of them is either politically feasible or will really have any appreciable effect on the underlying problems our health system faces.^{7,8,9,10} To really address the growing numbers of the uninsured, our overstrained safety net, and rising health costs, reform in North Carolina must take a different path.

Successfully strengthening the safety net in North Carolina means three mountains must be climbed. First, our tax system must be reformed so it collects (consistently from year-to-year) the revenue necessary to fund the public health safety net services we already have. Second, we must collect more revenue through the tax system to cover people now currently uninsured and make health insurance more affordable for those who are already insured—both reforms the public says it wants. Third, we need to develop a plan for reform that businesses, advocates for the uninsured, policymakers, and other stakeholders can support.

Reforming the Tax System to Fairly Meet the Health Needs of North Carolinians

Health and related human service programs account for approximately 25% of North Carolina's state budget spending. The majority of this spending is on safety net programs like Medicaid, Health Choice, and other health and child development programs.¹¹ All but about 5% of other state government spending goes for education, justice, and public safety programs. That nearly 95% of state spending is for these public services should not be surprising. Education, healthcare, and justice services all enjoy broad popular support among North Carolinians. For example, a recent survey of North Carolina voters shows that 87% support Medicaid to fund healthcare for low-income people in the state.¹²

North Carolina's tax system has not kept pace with the public's interest in funding these key state services. This is not an argument that more revenue needs to be generated from taxes,

just that the current laws on the books mean that the tax burden is distributed unfairly and cannot respond to our growing state population. Our tax system is antiquated and so full of loopholes that it does not fund state needs over time and is easily affected by economic downturns. An example of this is the sales tax that extends to most products while not covering services people increasingly buy instead of products. The person who used to pay sales tax on the purchase of a lawn mower now pays no sales tax on the purchase of a lawn mowing service. Because of problems like this, "families earning less than \$15,000 in North Carolina pay the greatest share of their income [10.9%] in state and local taxes while the top 1% of income-earners pay the lowest share of their income [6.3%] in taxes."¹³

"...our tax system must be reformed so it collects (consistently from year-to-year) the revenue necessary to fund the public health safety net services we already have."

Another example of why we need tax reform is the shift of the tax burden away from corporations to individuals.¹⁴ As revenues from corporate taxes decline, the state must look to individuals to make up the difference, often with inequitable results. A major Fortune 500 company in North Carolina, BB&T, had basically no state income tax liability (0.1%) from 2001-2003 despite making \$4.6 billion in profits.¹⁵ Without reform of our tax system, we will not have the money to fund current state safety net programs that have broad public support, like Medicaid and Health Choice, much less enough money to make improvements in the future.

Generating Revenue to Strengthen and Expand the Safety Net

A reformed tax system would better keep up with the growth of state safety net programs and services now available. However, any expansion to address the problems facing the safety net or to extend coverage to the growing uninsured population will need new revenue.

Recently a group of farmers came to demonstrate at the General Assembly in Raleigh with two demands: (1) keep and increase tax breaks for farmers, and (2) make health insurance more affordable.¹⁶ This call highlighted one of the main obstacles to strengthening the safety net and addressing the problem of the uninsured—people want the government to do something to make healthcare more affordable and accessible, but they believe they pay too much for government services already and want lower taxes. These two goals are simply not compatible.

Strengthening North Carolina's Medicaid and other safety

net programs to insure parents of already covered children would begin to reduce North Carolina's uninsured rate. This costs money. Ideas like establishing a statewide reinsurance pool for employees in small businesses with extremely high health bills could reduce small business health premiums significantly. This costs money. Allowing medically uninsurable North Carolinians to buy into state health plans would reduce the numbers of uninsured. This costs money.

Any one of these reforms is achievable within the context of North Carolina's \$15 billion budget, but at least some new revenue will have to be generated to meet these needs and the public's other priorities in education and public safety. The bottom line is that for significant health reforms to have a chance, people who want health reforms must also advocate for a tax system that will generate enough revenue to fund reforms.

Steps to Strengthen the Safety Net and Expand Health Insurance Coverage

Developing a plan to strengthen the safety net and extend affordable health coverage is the easy part, once enough revenue has been raised to achieve real reforms. Proposals abound, but funding them is always the critical component. The following proposals would each individually slash the number of people without health insurance. Enacting all of them would elevate North Carolina to the status of a national leader in reducing the costs of health insurance for business and individuals, while extending coverage to the uninsured.

- Expand Medicaid and North Carolina Health Choice (children's health insurance) to offer affordable coverage to low-income parents of children currently covered if a family's income is under 200% of federal poverty guidelines (\$31,340 annual income for a family of three).

- Direct more funding to safety net health centers like community health centers, rural health centers, and public health clinics to enable them to expand and provide services to the growing number of people either uninsured or covered by Medicaid.
- Allow childless adults, children, and parents to buy into the state employees' health insurance plan if their income is below 300% of federal poverty guidelines (\$47,010 annual income for a family of three). Charge premiums on a sliding-fee scale with families and individuals who have higher incomes paying the full cost of coverage.
- Establish a state high-risk insurance pool that would subsidize coverage for people who, because of a health condition, cannot find affordable coverage anywhere else.
- Start a state reinsurance pool for small and mid-size businesses that would take over paying for the health costs of any employee whose medical bills exceeded \$50,000. By removing the risk of paying for catastrophic care, employer health premiums would drop, and coverage would become more affordable.

Treading water is simply not acceptable. As costs mount in tandem with calls to cut Medicaid, North Carolina's major health safety net program; as employers find they can no longer afford coverage for employees; and as the numbers of uninsured grow, we cannot simply stand by. Federal action is unlikely, and North Carolina must begin to address the problem of affordable health coverage and the uninsured on its own. Without action by the federal government, it is unlikely that North Carolina will be able to completely strengthen the healthcare safety net and extend health coverage to 100% of people without health insurance. However, indifference in Washington is no excuse for North Carolina not beginning to address these serious problems with its own innovative solutions. **NCMJ**

REFERENCES

- 1 Searing A. The uninsured and Medicaid, NCMedJ, January/February 2002;63(1):52-54.
- 2 Jonathan Oberlander. 2005 Emerging Issues Forum, Raleigh, NC. February 7, 2005.
- 3 Wachino V, Schneider A, Ku L. Medicaid budget proposals would shift costs to states and be likely to cause reductions in health coverage. Center on Budget and Policy Priorities, Washington, DC. February 18, 2005. Available at: www.cbpp.org/2-18-05health.pdf. Accessed March 24, 2005.
- 4 Hoffman C, Carbaugh A, Cook A. Health insurance coverage in America: 2003 Data Update. Kaiser Family Foundation, Washington, DC. December 8, 2004. Available at: www.kff.org/uninsured/7153.cfm. Accessed March 24, 2005.
- 5 Kaiser Family Foundation. State Health Facts page. Available at: www.statehealthfacts.org. Accessed March 24, 2005.
- 6 Kaiser Family Foundation. Employer Health Benefits 2004 Annual Survey. Available at: www.kff.org/insurance/7148/sections/ehbs04-1-9.cfm. Accessed March 24, 2005.
- 7 For a discussion of the effect of medical malpractice legal changes on the cost of health insurance see: Economic and budget issue brief: Limiting tort liability for medical malpractice. Congressional Budget Office, Washington, DC. January 8, 2004. Available at: www.cbo.gov/ftpdocs/49xx/doc4968/01-08-MedicalMalpractice.pdf. Accessed March 24, 2005.
- 8 The effect of HSAs and high-deductible health plans has recently been studied by the Commonwealth Fund in: Half of insured adults with high-deductible health plans experience medical bill or debt problems. The Commonwealth Fund, New York, NY. January 27, 2005. Available at: www.cmwf.org/newsroom/newsroom_show.htm?doc_id=257751. Accessed March 24, 2005.
- 9 Oberlander J. The politics of health reform: Why do bad things happen to good plans? Health Affairs Web Exclusive. August 27, 2003; W3-391-W3-404. Available at: www.healthaffairs.org. Accessed on March 24, 2005.
- 10 Koppel R, Metlay JP, Cohen A, et al. Role of computerized physician order entry systems in facilitating medication errors. JAMA 2005;293:1197-1203.
- 11 Our state, our money: A citizens' guide to the North Carolina budget. North Carolina Progress Board, Raleigh, NC. September 2003. Available at: http://www.thepressboard.org/PDF/Citizens_Guide.pdf. Accessed March 24, 2005.

- 12 North Carolina Voters Support Medicaid. North Carolina Hospital Association, Cary, NC. Available at: www.ncha.org. Accessed March 24, 2005.
- 13 Cameron A. Following the money: A guide to North Carolina's tax system and a blueprint for reform and modernization," NC Justice Center's Budget and Tax Center, Raleigh, NC. October, 2004. Available at: <http://www.ncjustice.org/btc/2004pubs/Tax%20Primer04.pdf>. Accessed March 24, 2005.
- 14 Schofield, R. Taxes and the 2005 Session reform and modernization or... more of the same? NC Justice Center, Raleigh, NC. February 7, 2005. Available at: www.ncjustice.org/PolicyBrief/2005/NCPBv3-2Taxes.pdf. Accessed March 24, 2005.
- 15 Cameron A, McIntyre B. National report confirms North Carolina corporations pay little state corporate income tax, NC Justice Center's Budget and Tax Center, Raleigh, NC. February 2, 2005. Available at: www.ncjustice.org/Publicity/MRCorpTax2-2-05.doc. Accessed March 24, 2005.
- 16 Hartsoe S. Farmers seek favorable taxes. Raleigh News and Observer. March 3, 2005. Available at: <http://www.newsobserver.com/politics/politicians/legislature/story/2174420p-8555420c.html>.

4th Annual North Carolina Conference on Aging

October 19-21, 2005

**New Bern Riverfront Convention Center
and the Sheraton Grand Hotel**

Visit the Conference web site for:

The Call for Presentations (deadline is March 23, 2005)

Information updates regarding: sponsorship opportunities, advertising,
and exhibits as this information becomes available:

www.aging.unc.edu/nccoa/

North Carolina Conference on Aging

UNC Institute on Aging

720 Airport Road, CB #1030

Chapel Hill, NC 27599-1030

919-966-9444

ioa@unc.edu