Conclusion

Chapter 9

The number of people reporting access barriers in obtaining needed health care has increased over the last five years in North Carolina. Seventeen percent of North Carolinians reported that they could not see a doctor when they needed to because of costs, up from 12% in 2000.[1,2] There are many reasons people experience access barriers, including low health literacy, high health care costs, and lack of health care professionals. However, the lack of health insurance coverage is the foremost barrier to accessing care. There were more than 1.5 million non-elderly North Carolinians who were uninsured in 2006-2007, almost one out of every five non-elderly people in North Carolina. Compared to individuals with insurance, the uninsured are more likely to report delaying or foregoing needed care due to cost and are less likely to get preventive screenings or ongoing care for chronic conditions. As a result, uninsured adults are 25% more likely to die prematurely than adults with insurance.[3]

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Most uninsured individuals forgo health insurance coverage because of costs. Between 2000 and 2007, premiums for employer-sponsored family coverage grew more than five times faster than median wage earnings.[4] Health insurance has simply become too expensive for many people to afford. High premiums are also the main reason for the decline in employer-sponsored coverage.[5]

North Carolina has experienced a more pronounced growth in the percent uninsured than most of the country. Between 1999-2000 and 2006-2007, the percent of uninsured North Carolinians increased 29%, compared to an average national increase of 12%.[a] Part of the reason for this rapid increase in the uninsured is because of the decline in employer-sponsored insurance. North Carolina experienced a 12.5% decline in employer-sponsored coverage compared to 6.8% nationally. Most of the uninsured fall into one or more of three groups: 1) children in families with incomes below 200% of the federal poverty guidelines (FPG) (14%), 2) adults with incomes below 200% FPG (46%), and 3) people with a family connection to a small employer with less than 25 employees (36%). Together, these three groups comprise 79% of all of the uninsured in the state.

While many of the uninsured can obtain health care services from safety net providers, the safety net system is not robust enough to serve all in need. As a result, people either delay care or end up in the emergency department for their health care. The lack of health insurance has a negative impact on health status of the uninsured, and produces adverse consequences for society at large. Workers in poor health are more likely to work fewer days or hours and students in poor health have more difficulty learning in school.[6] In addition, uncompensated care for the uninsured creates an economic strain on health care institutions which is eventually borne, in part, by all North Carolinians through taxes and higher insurance premiums. Individuals pay, on average, $438 more per year for their

a Unless otherwise noted, all data on the uninsured are based on North Carolina Institute of Medicine analysis of the Current Population Survey's Annual Social and Economic Supplement, published by the US Census Bureau.

individual health insurance coverage, and families pay an additional $1,130 to help pay for uncompensated care provided to the uninsured.[7]

The North Carolina General Assembly directed the North Carolina Institute of Medicine (NCIOM) to convene a study group to examine and recommend options to expand access to appropriate and affordable health care in North Carolina. The Health Access Study Group was charged with presenting a final report to the 2009 General Assembly.[b]

The Study Group met five times between September 2008 and January 2009. The Study Group examined the findings and recommendations from other NCIOM studies, as well as strategies to expand access in other states or being considered at the federal level. The majority of the Study Group's work focused on ways to provide health insurance coverage to the three groups that constitute the majority of the North Carolina uninsured: children in families with incomes below 200% FPG, adults with incomes below 200% FPG, and people with a family connection to a small employer.

The state will need to address costs, quality, population health, and coverage to ensure access to affordable health care.

The Study Group also recognized the importance of strengthening the existing safety net. This is important as a short-term strategy to expand access to health care services for the uninsured. However, it is not a long-term solution. Ultimately, the state neeeds to ensure that everyone has health insurance coverage. North Carolina can begin to address this problem by expanding existing programs and developing new options to phase-in coverage to more people. The longer term goal is to develop public and private approaches that will make health insurance coverage affordable to everyone, and to couple these approaches with an individual mandate to require people to have insurance coverage.

The state will need to address costs, quality, population health, and coverage to ensure access to affordable health care. Unless ways to reduce rising health care costs are identified, North Carolina will be unable to afford health care for anyone in the state—let alone afford expanding coverage to all of the uninsured. Health care quality, improving population health, reducing cost escalation, and access to care are all interrelated, and must be examined holistically to develop long-term solutions to our current health care crisis. More work is needed to examine these issues and identify strategies for North Carolina to reign in rising health care costs, enhance health care quality, and improve population health.

The issue of provider supply was also examined. North Carolina is predicted to experience a provider shortage in the next 10-20 years as a result of a large cohort of physicians reaching retirement age, increased demand for services, and an aging of the general population.[8] As a result, the supply of practitioners is likely to be inadequate, even if the state could expand coverage to all.

b Section 31 of Session Law 2008-181.

The following is a list of the Study Group's recommendations along with the agency or organization charged with addressing the recommendation. The Study Group proposed a plan for phasing in the recommendations. Each phase corresponds with a two-year legislative cycle. Eight of the 17 recommendations were considered top priorities, although all of the recommendations are important.

	Phase 1 (SFY 2010-2011)	Phase 2 (SFY 2012-2014)	Phase 3 (SFY 2015-2016)	Phase 4 (SFY 2017-2018)
Access and Cost				
Recommendation 2.1 a) The North Carolina General Assembly should direct the North Carolina Institute of Medicine's Health Access Study Group to continue to meet to consider: 1) Options to reduce escalating health care costs (cost-containment), 2) The costs of the different proposals, 3) The amount that individuals and families should reasonably be expected to contribute for health insurance premiums and other out of pocket costs (affordability), 4) Changes in federal laws which may impact on health insurance coverage and financing options to expand coverage to the uninsured, 5) Whether other options should be considered for universal coverage (including but not limited to single payer or multi-payer systems), 6) Other ways to make health insurance coverage affordable to small employers, and 7) Other options to ensure that there are sufficient numbers of health professionals in the future to meet the state's growing and aging population b) The Health Access Study Group should report its findings and recommendations no later than the convening of the 2010 Session of the North Carolina General Assembly.	✓ NCGA, NCIOM Health Access Study Group			
Recommendation 2.2 The North Carolina General Assembly should require individuals to purchase health insurance coverage, as long as insurance coverage is affordable. In order to effectively mandate health insurance coverage for individual citizens of the state, subsidy programs will need to be in place for lower-income populations. The individual mandate may require a "phasing-in" to allow for a sliding scale subsidy to be put into place for populations up to 300% of the federal poverty guidelines.				✓ NCGA

	Phase 1 (SFY 2010-2011)	Phase 2 (SFY 2012-2014)	Phase 3 (SFY 2015-2016)	Phase 4 (SFY 2017-2018)
Covering Low-Income Children				
Recommendation 4.1 (PRIORITY RECOMMENDATION) a) The North Carolina Division of Medical Assistance (DMA) should simplify the eligibility determination and recertification process to facilitate the enrollment of eligible Medicaid and NC Health Choice individuals. Specifically, DMA should: 1) Pilot test the use of North Carolina administrative databases to verify income, and if accurate, use administrative income databases to verify income for eligibility and recertification for all, or a portion, of the applicants and recipients. 2) Develop a system of presumptive eligibility for children. 3) Allow rolling recertification periods to enable individuals to return their recertification forms anytime within the three months prior to the end of their certification period. 4) Use eligibility information from other public programs (e.g. food stamps, Women, Infants and Children (WIC), free and reduced school meals) to determine Medicaid and NC Health Choice eligibility. 5) Use other efforts to reduce the percentage of procedural closings during the eligibility and recertification process. b) DMA should expand outreach efforts to identify and enroll individuals who are eligible for Medicaid and NC Health Choice. Specifically, DMA should: 1) Ensure that Department of Social Services (DSS) eligibility workers are outstationed at Disproportionate Share Hospitals and federally qualified health centers (as required by federal law), and at health departments or other community health providers that serve a large number of potentially eligible Medicaid recipients. Outstationed DSS workers should help individuals fill out Medicaid and NC Health Choice applications and recertification forms and determine eligibility. 2) Train community organizations and other health professionals to assist potentially eligible individuals in filling out applications and recertification forms. c) The Department of Public Instruction and Local Education Authorities, in coordination with the outreach efforts of the Department of Health and Human Services and local DSSs, should actively work to promote health insurance coverage to children eligible for public programs.	✓ DMA, DSS, DPI, LEA			

	Phase 1 (SFY 2010-2011)	Phase 2 (SFY 2012-2014)	Phase 3 (SFY 2015-2016)	Phase 4 (SFY 2017-2018)
Recommendation 4.2 (PRIORITY RECOMMENDATION) The North Carolina General Assembly should: a) Remove the cap on coverage of eligible children in the NC Health Choice program. b) Continue to implement Kids' Care, with coverage of children up to 250% of the federal poverty guidelines (FPG). If sufficient federal and state funds are available, Kids Care should be expanded to cover children up to 300% FPG.	✓ NCGA (250% SFY 2010, if sufficient funds 300% or SFY 2011)			
Recommendation 4.3 The North Carolina General Assembly should expand Medicaid to implement the Family Opportunity Act which allows children who meet the Supplemental Security Income (SSI) disability standards with family incomes of up to 300% of the federal poverty guidelines to buy-into the Medicaid program.		✓ NCGA		
Covering Low-Income Adults				
Recommendation 5.1 (PRIORITY RECOMMENDATION) The North Carolina General Assembly and the Governor's Office should work with the North Carolina Congressional delegation to support Medicaid reform that provides fiscal relief to the states and gives states the flexibility and funding to expand coverage to low-income adults without categorical restrictions, along with other efforts to provide an economic stimulus to the state.	✓ NCGA, Gov.'s Off., NC Congressional Delegation			
Recommendation 5.2 (PRIORITY RECOMMENDATION) The North Carolina Division of Medical Assistance (DMA) should conduct outreach activities, and simplify the eligibility determination and recertification process to facilitate the enrollment of Medicaid adults. In addition to efforts undertaken for children, DMA should explore other options applicable to adults, including, but not limited to: eliminating the resource limits for low-income parents or childless adults with incomes below 100% of the federal poverty guidelines and expand the allowable resource limits for other Medicaid eligibles, and expand the certification period from 6 to 12-months.	✓ DMA			
Recommendation 5.3 (PRIORITY RECOMMENDATION) The North Carolina General Assembly should direct the Division of Medical Assistance (DMA) to seek a Medicaid Section1115 waiver to cover more low-income adults. The waiver should be implemented in two phases. a) The first phase should be to expand Medicaid coverage to low-income adults with incomes below 100% of the federal poverty guidelines (FPG).	✓ NCGA, DMA (develop and submit waiver to CMS for coverage up to 200% FPG in two phases)	✓ DMA (implement waiver upon approval, 100% FPG)	✓ DMA (implement waiver upon approval, 200% FPG)	

	Phase 1 (SFY 2010-2011)	Phase 2 (SFY 2012-2014)	Phase 3 (SFY 2015-2016)	Phase 4 (SFY 2017-2018)
1) DMA should develop a limited benefit package that emphases prevention, primary care, chronic disease management, a limited formulary and limited hospitalizations. 2) Adults covered under this initiative should be enrolled in Community Care of North Carolina (CCNC). 3) DMA should seek to identify other state funds already being used to provide services to this population that could be used as part of the state match for this new Medicaid coverage. b) The second phase should be to expand coverage to adults with incomes between 100%-200% FPG. 1) The adults covered through this waiver should receive the same benefit package and be enrolled in CCNC. 2) DMA should develop a sliding scale for premiums and cost sharing for this group. However, in no event can the combined premium or cost sharing exceed 5% of the families gross income. c) DMA should develop a premium assistance program to enable Medicaid-eligible recipients to use Medicaid funds to pay for employer-sponsored insurance or private non-group insurance purchased in the private market. d) In order to expand the availability of coverage in the small group market, DMA should work with North Carolina Community Care Network, Inc. and private insurers to explore the potential for a lower cost insurance product for small businesses that were previously uninsured, utilizing the CCNC network. Medicaid-eligible recipients who work for employers who enroll in this lower-cost public private partnership plan shall also be eligible for premium assistance. The product may include the following features: 1) Connecting all enrollees with a medical home . 2) A more limited benefit package, emphasizing prevention, primary care and chronic disease management. 3) Ensuring that enrollees with chronic diseases or complex health problems have access to care management and disease management through CCNC networks. 4) An emphasis on wellness, health promotion and personal responsibility. 5) Provider reimbursement for low-income populations with incomes <200% FPG at lower levels than commercial rates.	DMA, CCNC, private insurers (discussions to determine feasibility of public-private, low cost insurance product)	DMA (implement premium assistance)		

	Phase 1 (SFY 2010-2011)	Phase 2 (SFY 2012-2014)	Phase 3 (SFY 2015-2016)	Phase 4 (SFY 2017-2018)
6) A requirement that small employers that purchase health insurance coverage through this public private partnership also offer Section 125 plans.				
Recommendation 5.4 (PRIORITY RECOMMENDATION) The North Carolina General Assembly should direct the Division of Medical Assistance (DMA) to seek a Medicaid Section 1115 waiver or implement other Medicaid options to provide interconceptional coverage to low-income women with incomes below 185% of the federal poverty guidelines who have had a high-risk birth. (For purposes of this recommendation, high-risk births are those with infants weighing less than 1500 grams, born less than 34 weeks gestation, born with a congenital anomaly, and/or who has died in the neonatal period (first 28 days of life) within the past two years). a) Interconceptional care should be limited to two years following the birth, or until the subsequent birth, whichever occurs sooner. b) DMA should develop a benefit package to improve interconceptional care in order to decrease poor birth outcomes in subsequent pregnancies. c) DMA should explore whether the cost savings from improved health outcomes will offset the cost of providing Medicaid coverage to this targeted population.	✓ NCGA, DMA (implement if no waiver needed, develop and submit waiver to CMS, if necessary)	✓ (Implement after CMS waiver approved, if waiver needed)		
Recommendation 5.5 The North Carolina General Assembly should revise North Carolina General Statute §58-50-180(d) to clarify that the North Carolina Health Insurance Risk Pool has the legal authority to offer premium subsidies. a) The North Carolina General Assembly should appropriate $18 million in recurring funds to help subsidize on a sliding-scale basis the Pool premium for low-income persons with incomes below 300% of the federal poverty guidelines. b) The Pool should pursue sources of funding for premium subsidies, including but not limited to philanthropic foundations to supplement any state funds appropriated for that purpose.		✓ NCGA $18m (NR) NC Risk Pool		

	Phase 1 (SFY 2010-2011)	Phase 2 (SFY 2012-2014)	Phase 3 (SFY 2015-2016)	Phase 4 (SFY 2017-2018)
Small Employers				
Recommendation 6.1 The North Carolina Department of Insurance should obtain from insurers the necessary data to study how changing the existing small group rating laws to eliminate self-employed groups of one impacts small group rates. The Department of Insurance should use the data to study: a) The impact of changes on the cost of insurance for small groups 2-50, for those who under current small group law qualify as self-employed groups of one, and for enrollees of the high-risk pool. b) The impact on the total number of covered lives in the small group market and the high-risk pool.	✓ DOI (study and seek changes if appropriate)			
Recommendation 6.2 The North Carolina General Assembly should provide tax subsidies or otherwise subsidize the cost of health insurance premiums for small employers. The subsidy may mirror the following example, but successful programs in other states should be reviewed to determine the appropriate levels of subsidy, income level, and employee participation to ensure the most employers and employees participate in purchasing health insurance. a) Funding should be targeted to small employers with15 or fewer eligible employees, at least 30% of which are low-wage workers earning $35,000 or less per year. The North Carolina General Assembly should provide subsidies that will reduce total premiums by 30% for the lower wage workers. To qualify for subsidy: 1) Small employers that have not previously offered health insurance coverage in the last year must pay at least 50% of the costs of employee coverage and enroll at least 75% of eligible employees who do not have other creditable coverage. 2) Small employers that currently offer health insurance coverage must pay at least 50% of the cost of employee coverage, and/or enroll 90% of eligible employees who do not have other creditable coverage. 3) Health plans must include medical management of resources to reduce cost escalation.	✓ NCGA (study to determine costs)	✓ NCGA (implement)		

	Phase 1 (SFY 2010-2011)	Phase 2 (SFY 2012-2014)	Phase 3 (SFY 2015-2016)	Phase 4 (SFY 2017-2018)
Safety Net				
Recommendation 7.1 (PRIORITY RECOMMENDATION) The North Carolina General Assembly should increase funding to expand safety net capacity. The North Carolina General Assembly should: a) Appropriate $8 million in new recurring funds in SFY 2010 to the Office of Rural Health and Community Care to support the Community Health Center Grants Program. Funding should be used to expand the safety net infrastructure so that safety net organizations can hire staff to support community-based medical homes and expand the availability of preventive, primary, chronic disease management, specialty, dental, behavioral health and/or pharmacy services for the uninsured. Some of the funds should be targeted to support safety net organizations that are providing a disproportionate share of care to the uninsured. b) Appropriate $2.2 million in new recurring funds in SFY 2010 to the Office of Rural Health and Community Care to support the HealthNet program. Funds should be used to sustain existing community collaborations to care for the uninsured and expand networks to other parts of the state.	✓ NCGA $8m SFY 2010 (R) (Community health center grants) $2.2m SFY 2010 (R) (HealthNet) ORHCC			
Workforce				
Recommendation 8.1 a) The North Carolina General Assembly should increase funding to increase the supply of primary care and specialty providers. Specifically, the North Carolina General Assembly should appropriate: 1) $40 million in recurring funds to support the expansion of the medical schools at The University of North Carolina at Chapel Hill and East Carolina University Brody School of Medicine. State funding should be targeted to expansion efforts that result in: i) Increased numbers of physicians who set up and maintain practices in underserved areas. ii) Increased numbers of physicians who practice in primary care or other shortage specialties needed to meet the health care needs of North Carolina. iii) Increased numbers of underrepresented minority physicians. iv) Greater interdisciplinary didactic and clinical team training among physicians, nurse practitioners, physician assistants, and certified nurse midwives, nurses, and other health care professionals.	✓ NCGA $1.2m (R) in SFY 2010 and 2011; $3 m (NR) in SFY 2010 and 2011 for capital costs for community residency programs AHEC (begin residency expansion)	✓ NCGA $1.2m (R) in SFY 2012 and 2013 $2 m (NR) in SFY 2012 for capital costs for community residency programs AHEC (continue residency expansion)	✓ NCGA $1.2m (R) in SFY 2014 AHEC (continue residency expansion)	

	Phase 1 (SFY 2010-2011)	Phase 2 (SFY 2012-2014)	Phase 3 (SFY 2015-2016)	Phase 4 (SFY 2017-2018)
2) $1.2 million in recurring funds and/or Medicaid Graduate Medical Education to the North Carolina Area Health Educations Centers (AHEC) program in each year over the next five years to fund 12 new residency positions per year across the state targeted toward the high priority specialty areas of primary care, general surgery, psychiatry or other specialty shortage areas. i) This funding should be provided to AHEC, with AHEC then making grants to AHEC and university based residency programs that agree to expand residency slots and create programs designed to graduate physicians likely to settle in rural and other underserved areas of the state. ii) $3million in non-recurring funds in SFY 2010 and 2011 and $2 million in non-recurring funds in SFY 2012 should be provided to help pay for the capital costs involved in developing new community-based residency programs across the state. b) The North Carolina General Assembly should direct General Administration within the University of North Carolina System to explore the possibility of further expansion of physician assistants and nurse practitioner programs in the University of North Carolina System in order to: 1) Increased numbers of nurse practitioners and physician assistants who set up and maintain practices in underserved areas 2) Increased numbers of nurse practitioners and physician assistants who practice in primary care or other shortage specialties needed to meet the health care needs of North Carolina 3) Increased numbers of underrepresented minority nurse practitioners and physician assistants. 4) Greater interdisciplinary didactic and clinical team training among physicians, nurse practitioners, physician assistants, certified nurse midwives, nurses and other health care professionals.	NC University System (study need for PA and NP expansion)	NC University System (Begin phase in medical school expansion) (Implement PA and NP expansion if study finds necessary)	NC University System (Continue phase in of medical school expansion)	
Recommendation 8.2 (PRIORITY RECOMMENDATION) In order to maintain and expand access to health care services for low-income and underserved populations, the North Carolina General Assembly should: a) Continue to support the Community Care of North Carolina (CCNC) program. b) Continue to tie Medicaid reimbursement to physicians at 95% of the Medicare rates.	✓ NCGA $1.9m (R) (SFY 2010) DMA (continue 95% Medicare reimburse.)	✓ DMA (increase reimburse. rates)		

	Phase 1 (SFY 2010-2011)	Phase 2 (SFY 2012-2014)	Phase 3 (SFY 2015-2016)	Phase 4 (SFY 2017-2018)
c) Direct the Division of Medical Assistance to increase the payment for primary care practitioners practicing in health professional shortage areas either by increasing reimbursement rates or establishing a higher per member per month (pmpm) CCNC payment. d) The North Carolina General Assembly should appropriate $1,915,600 million in recurring funds to the North Carolina Office of Rural Health and Community Care (ORHCC). Of this amount: 1) $350,000 should be appropriated to provide technical assistance to communities to help identify community needs and practice models that can best meet these needs and to provide technical assistance to small practices or solo practitioners practicing in medically underserved communities or serving underserved populations; 2) $1.5 million should be appropriated to pay for loan repayment and financial incentives to recruit and retain primary care physicians, physician assistants, nurse practitioners, and certified nurse midwives, psychiatrists, psychiatric physician assistants, psychiatric nurse practitioners, general surgeons and dentists to rural and underserved communities; and 3) $65,600 should be appropriated to expand the number of ORHCC staff who recruit practitioners into health professional shortage areas. 4) ORHCC should place a special emphasis on recruiting and retaining underrepresented minority, bilingual and bicultural providers to work in underserved areas or with underserved populations.	ORHCC (implement incentives)			
Recommendation 8.3 In order to expand the health professional workforce in underserved areas of the state: a) The North Carolina General Assembly should direct the North Carolina Office of Rural Health and Community Care (ORHCC) to explore different forms of financial incentives or other systems to encourage providers to establish and remain in practice in underserved areas or with underserved populations, and report the findings back to the 2011 Session of the North Carolina General Assembly. The ORHCC should work with the North Carolina Medical Society Foundation and other relevant groups to identify appropriate incentives which may include, but not be limited to: tax credits, increased reimbursement, malpractice premium subsidies or grants to help practices purchase electronic health records.	✓ NCGA (continue support of existing programs) ORHCC (study forms of financial incentives and report to NCGA in 2011 session)			

	Phase 1 (SFY 2010-2011)	Phase 2 (SFY 2012-2014)	Phase 3 (SFY 2015-2016)	Phase 4 (SFY 2017-2018)
b) The North Carolina General Assembly should continue support to existing programs to enable them to work with practices in underserved areas to assist with systems redesign and quality improvement initiatives. These strategies could include, but not be limited to providing support to small rural hospitals to help pay for call coverage or use of hospitalists.				
Recommendation 8.4 In order to improve the skills of health care professionals and practice managers to handle the business aspects of running a health care practice: a) The North Carolina General Assembly should appropriate $250,000 in recurring funds to the North Carolina Office of Rural Health and Community Care (ORHCC). ORHCC should use funding to support technical assistance provided through the Office of Rural Health and Community Care and the North Carolina Medical Society Foundation *PracEssentials* programs to practices in underserved areas or serving underserved populations. b) The University of North Carolina system, North Carolina community colleges, and North Carolina independent colleges and universities should offer courses that can improve the skills of existing practice managers and increase the supply of new practice managers across the state. These courses should be targeted to underserved areas of the state. c) The North Carolina Area Health Education Centers Program, ORHCC, Community Practitioner Program, North Carolina community colleges, and North Carolina independent colleges and universities should develop educational and continuing education courses for existing practitioners and staff to enhance the business skills needed to maintain a viable practice. d) North Carolina foundations should consider funding start-up programs to community colleges and other organizations to enhance the skills of practice managers and providers and programs targeted to underserved areas.	✓ NCGA (250K (R) (SFY 2010) ORHCC (provide technical support)	✓ NC University System, NC community colleges, other colleges (offer courses in practice mngr.) AHEC, ORHCC, NC community colleges, other colleges (develop courses for practice mngr.)		

References

1 North Carolina State Center for Health Statistics, North Carolina Department of Health and Human Services. Behavioral Risk Factor Surveillance System, 2000. http://www.schs.state.nc.us/SCHS/brfss/2000/. Published Oct 24, 2003. Accessed January 5, 2009.

2 North Carolina State Center for Health Statistics, North Carolina Department of Health and Human Services. Behavioral Risk Factor Surveillance System, 2007. http://www.schs.state.nc.us/SCHS/brfss/2007/. Published June 2, 2008. Accessed January 5, 2009.

3 Families USA. Dying for coverage in North Carolina. http://www.familiesusa.org/assets/pdfs/dying-for-coverage/north-carolina.pdf. Published April 2008. Accessed November 25, 2008.

4 Families USA. Premiums versus paychecks a growing burden for North Carolina's workers. http://www.familiesusa.org/assets/pdfs/premiums-vs-paychecks-2008/north-carolina.pdf. Published September 2008. Accessed December 2, 2008.

5 Chernew M, Cutler DM, Keenan PS. Increasing health insurance costs and the decline in insurance coverage. *Health Serv Res.* 2005;40(4):1021-1039.

6 Hadley J; Kaiser Commission on Medicaid and the Uninsured, Henry J. Kaiser Family Foundation. Sicker and poorer: the consequences of being uninsured. http://www.kff.org/uninsured/upload/Full-Report.pdf. Published May 2002. Accessed November 25, 2008.

7 Families USA. Paying a premium: the added cost of care for the uninsured. http://www.familiesusa.org/assets/pdfs/Paying_a_Premium_rev_July_13731e.pdf. Published June 2005. Accessed November 25, 2008.

8 Ricketts TC. Practitioner supply and health care access in North Carolina. Presented to: the North Carolina Institute of Medicine Health Access Study Group; October 21, 2008; Morrisville, NC. Accessed December 12, 2008.