# Executive Summary

North Carolinians are facing increasing barriers to accessing needed health care services. Access to care is likely to become even more difficult with the recent downturn in the economy, as a large number of people lose their jobs and subsequently their health insurance. While there are many barriers to accessing health care, the foremost barrier is the lack of health insurance. In North Carolina, the uninsured are four times more likely than people with insurance coverage to report that they did not seek necessary medical care because of costs (47% vs. 10% respectively) or that they had no usual source of care (59% vs. 14%).[1] The uninsured are therefore less likely to get preventive screenings or receive ongoing care for chronic conditions.[2] Ultimately, uninsured adults are 25% more likely to die prematurely than adults with health insurance.[2] Although there is a safety net system in place to treat the uninsured, the system does not have the infrastructure or the funds to treat all of the uninsured in the state.[a]

**While there are many barriers to accessing health care, the foremost barrier is the lack of health insurance.**

North Carolina has experienced more rapid growth in the percent of people lacking health insurance than the nation. In 2006-2007, nearly one-in-five non-elderly individuals in North Carolina, more than 1.5 million people, lacked health insurance, a 29% increase from 1999-2000.[b] Comparatively, the percent of uninsured in the nation increased only 12% during the same time period. The percent of North Carolinians with employer-sponsored insurance (ESI) declined as well. Between 1999-2000 and 2006-2007, North Carolina saw a 12.5% decrease in ESI compared to a 6.8% decrease nationally.

The uninsured are a diverse group that includes individuals from all income levels, and all racial, ethnic, and age groups. Nonetheless, certain populations are more at risk for being uninsured than others. The majority of the uninsured in North Carolina fall into at least one 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 approximately four-fifths, or 79%, of all the uninsured in the state.

Lack of coverage has a negative effect on both the uninsured and society at large. Many uninsured forego or delay care and end up in the emergency department for their health care. The uninsured, on average, pay about one-third of their medical bills out of pocket. The remainder of the costs—known as uncompensated care—is shifted to other payers through higher taxes and insurance premiums. In North Carolina, individuals pay an average of $438 more a year and families pay an

a Information about available safety net health care resources for the uninsured at the county level is available at www.nchealthcarehelp.org.

b 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.

additional $1,130 per year on health insurance premiums to help cover the cost of uncompensated care for the uninsured.[3] Therefore, the high and increasing number of uninsured has a direct effect on the finances of those who have health insurance coverage.

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, and to present a final report to the 2009 General Assembly.[c] The Health Access Study Group was co-chaired by Representative Hugh Holliman, District 81, North Carolina House of Representatives; Senator Tony Rand, District 19, North Carolina Senate; and L. Allen Dobson, MD, FAAFP, Vice President, Clinical Practice Development, Carolinas HealthCare System. It included 38 additional Study Group and Steering Committee members. The Study Group met a total of five times between September 2008 and January 2009 to develop the final report for the North Carolina General Assembly.

**Health insurance premiums increased 119% between 1999 and 2008, compared to 34% for wages and 29% for overall inflation.**

***Health Care Costs, Coverage, and Quality:*** Most of the Study Group's work focused on expanding coverage to the three groups most likely to be uninsured. However, the Study Group recognized that it is necessary to also study costs, quality, and coverage to ensure access to affordable health care. Health insurance premiums in the United States are increasing much more rapidly than wages or general inflation. Premiums increased 119% between 1999 and 2008, compared to 34% for wages and 29% for overall inflation.[4] The rapid growth in premiums has led to decreases in the availability of ESI and an increasing number of uninsured.[5] Premium growth has been spurred by increases in underlying medical costs, including the high cost and utilization of medical technology and prescription drugs, growth in the prevalence of chronic illnesses, and uncompensated care for the uninsured.[6-10] Unless ways to reduce rising health care costs can be identified, we will be unable to afford health care for anyone in the state—much less extend affordable coverage to all of the uninsured. More work is needed to examine the issues of cost, quality, and coverage and to identify strategies for North Carolina to reign in rising health care costs, enhance health care quality, and improve population health.

In addition, the Study Group recognized that the state will not be able to fully address costs, quality, or access without also ensuring that everyone has health insurance. In a voluntary insurance system, in which individuals are not required to have health insurance, people with pre-existing health problems and/or greater health risks are more likely to purchase coverage than those in good health, even when facing identical insurance premiums. As a result, the average cost of premiums is higher than if everyone had coverage. The following is a summary of the Study Group's costs, quality, and coverage recommendations. The full recommendations are included in the report in Chapter 2.

c Section 31 of Session Law 2008-181.

## Recommendation 2.1

**The North Carolina General Assembly should direct the North Carolina Institute of Medicine's Health Access Study Group to continue to meet to consider costs, cost-containment, the affordability of health insurance, options for universal coverage, options to make coverage more affordable for small employers, and strategies to ensure there is an adequate supply of health professionals to meet the health care needs of the state. The Health Access Study Group should report its findings and recommendations to the North Carolina General Assembly no later than the convening of the 2010 Session.**

## Recommendation 2.2

**The North Carolina General Assembly should require individuals to purchase health insurance coverage, as long as insurance coverage is affordable. 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.**

***Expanding Coverage to Low-Income Children:*** Children lacking health insurance are more likely to forego or delay care and have less access to health care services than insured children.[11] Expanding coverage to low-income children will increase access to care and improve the health of children in North Carolina. Children in families with incomes less than 200% FPG are the children most likely to be uninsured, even though most of these children are already eligible for either Medicaid or NC Health Choice (the State Children's Health Insurance Program (SCHIP)). Approximately 60% of uninsured children (186,000 children) are currently eligible for, but not enrolled in, one of these two programs. Expanding outreach and simplifying the enrollment and recertification process will help enroll and cover more eligible children as well as retain those children upon recertification.

**Children lacking health insurance are more likely to forego or delay care and have less access to health care services than insured children.**

There has been recent growth in the percent of uninsured children with family incomes between 200%-300% FPG. In the 2008 Session, the North Carolina General Assembly addressed this growth by giving the Division of Medical Assistance (DMA) the authority to implement NC Kids' Care, a publicly-subsidized health insurance program for uninsured children with family incomes between 200%-250% FPG.[d] The program would cover an additional 9% of uninsured children with an expansion to 250% FPG, growing to 14% with an expansion to 300% FPG.[12] An additional strategy for expanding coverage to children in families with higher incomes is to expand Medicaid coverage for children with disabilities in families with incomes up to 300% FPG, as granted by the Family Opportunity Act.[e]

d Section 10.12(c) of Session Law 2008-107.

e The Family Opportunity Act allows states to provide wrap-around Medicaid coverage for children who have private insurance coverage, in order to provide better coverage to meet the special health care needs of children with disabilities.

In addition, in the last seven years, the North Carolina General Assembly has established growth caps for the NC Health Choice program which would restrict the aforementioned expansion strategies. To successfully expand coverage to low-income children, this cap must be removed. A summary of the Study Group's recommendations on expanding coverage for low-income children is listed below. The full recommendations are included in Chapter 4 of the report.

## Recommendation 4.1 (PRIORITY RECOMMENDATION)

**The North Carolina Division of Medical Assistance should simplify the eligibility determination and recertification process to facilitate the enrollment of individuals eligible for Medicaid and NC Health Choice and should expand outreach efforts to identify and enroll individuals who are eligible for Medicaid and NC Health Choice. The Department of Public Instruction and Local Education Authorities should actively work to promote health insurance coverage to children eligible for public programs, in coordination with the outreach efforts of the Department of Health and Human Services and local Departments of Social Services.**

## Recommendation 4.2 (PRIORITY RECOMMENDATION)

**The North Carolina General Assembly should remove the cap on coverage of eligible children in the NC Health Choice program. The North Carolina General Assembly should continue with implementation of NC Kids' Care up to 250% of the federal poverty guidelines (FPG), and if sufficient funds are available, expand coverage to 300% FPG.**

## 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 disability standards with family incomes of up to 300% of the federal poverty guidelines to buy into the Medicaid program.**

***Expanding Coverage to Low-Income Adults:*** Expanding coverage to low-income adults is more difficult than expanding coverage for children. The majority of low-income adults in North Carolina are not currently eligible for public programs due to restrictions in federal laws. The federal Medicaid laws limit eligibility to certain "categories" of low-income adults, commonly referred to as categorical restrictions. In general, adults only qualify for Medicaid if they are low-income, meet certain resource limits, and fall into one of four categories: pregnant women, adults who are parents of dependent children under age 19, adults who are disabled,

f There are certain limited Medicaid programs which cover certain categories of low-income adults who are not disabled or elderly. For example, North Carolina provides family planning coverage to certain low-income adults with incomes up to 185% of the federal poverty guidelines. In addition, under certain circumstances, North Carolina also provides coverage to women who have been diagnosed with breast or cervical cancer.

or adults who are at least 65 years old.[f] Childless, non-elderly, and non-disabled adults cannot qualify for Medicaid regardless of how poor they are. Even if the uninsured person is the right "category" of person (i.e. is categorically eligible), the person may not qualify because of income or resource restrictions. These income and resource restrictions are set by the state. The lowest threshold applies to parents of dependent children; they can only qualify for Medicaid if their income is less than about 50% FPG.

There are several challenges to expanding coverage to low-income adults. Health insurance coverage is generally too expensive in the private market. An adult living in poverty would have to spend 39% of his or her income to purchase comprehensive insurance in the private market (assuming that the individual paid the average total premium cost of an employer-sponsored plan). An uninsured adult with an income equal to 200% FPG ($42,400/year for a family of four in 2008) would have to pay 19% of his or her income for a similar policy. The state could expand Medicaid to cover more uninsured adults by increasing the income thresholds for those individuals who are otherwise categorically eligible. In addition, there are some low-income adults who are eligible but not enrolled for public programs. Increased outreach and simplification of eligibility, enrollment, and recertification would aid in enrolling and retaining these individuals. To cover all low-income adults, categorical restrictions would need to be eliminated (through federal action) or North Carolina would need to obtain a waiver of federal Medicaid laws.

**An adult living in poverty would have to spend 39% of his or her income to purchase comprehensive insurance in the private market.**

The Health Access Study Group recognized the difficulties of seeking additional state funds to expand Medicaid in the midst of a major recession. Medicaid enrollment typically grows during a recession as more people lose their jobs, income, and health insurance coverage. Additional state funding will be needed to expand coverage to all those who will become eligible within the current eligibility limits, as a result of reduced earnings, or to those who are identified through improved outreach efforts. The federal government can assist North Carolina in maintaining current eligibility limits, as well as expanding coverage, by providing increased federal fiscal relief to the states.

While the state could expand coverage to low-income parents up to 200% FPG without a waiver, North Carolina should instead submit a Medicaid Section 1115 waiver to cover all low-income adults. In addition to covering more adults, a waiver provides other advantages to the state. Under a Medicaid Section 1115 waiver, states can offer a limited benefit package and, if necessary, limit expansion to a certain number of enrollees, both of which would limit the cost of expansion. North Carolina could further reduce the cost of expansion by enrolling new Medicaid recipients into Community Care of North Carolina, and use Medicaid funds to leverage an enrollee's existing access to employer-sponsored insurance (ESI). One of the major drawbacks of waivers is that it generally takes several years to obtain approval from the US Centers for Medicare and Medicaid Services. In the interim, North Carolina should expand coverage to women who have had a high-risk birth in the prior two years. This expansion would cover a very high-risk, high-cost subset of the uninsured.

The Health Access Study Group also examined options to make the high risk pool more affordable. Inclusive Health (also known as the North Carolina Health Insurance Risk Pool) currently provides coverage to individuals who cannot obtain affordable health insurance coverage in the non-group (individual) market because they have a pre-existing medical condition. Because premiums for this program are higher than for typical plans, some Inclusive Health beneficiaries will require help paying their premium. Subsidies may also help with penetration into the market.

A summary of the Study Group's recommendations on covering low-income adults is listed below. The full set of recommendations can be found in Chapter 5.

## 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.**[g]

## 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 adults eligible for Medicaid. In addition to efforts undertaken for children, DMA should explore other options applicable to adults.**

## Recommendation 5.3 (PRIORITY RECOMMENDATION)

**The North Carolina General Assembly should direct the Division of Medical Assistance (DMA) to seek a Medicaid Section 1115 waiver to cover more low-income adults. The waiver should be implemented in two phases: 1) cover low-income adults up to 100% of the federal poverty guidelines (FPG), and 2) cover low-income adults up to 200% FPG. 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. 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 employers that were previously uninsured, utilizing the Community Care of North Carolina network.**

g The Study Group supports the recently passed American Recovery and Reinvestment Act of 2009 (Pub L No. 111-005) that provides fiscal relief to the states to help pay for increasing Medicaid enrollment.

## Recommendation 5.4 (PRIORITY RECOMMENDATION)

**The North Carolina General Assembly should direct the Division of Medical Assistance 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.**

## 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. The North Carolina General Assembly should appropriate $18 million in recurring funds to help subsidize the Pool premium for low-income persons with incomes below 300% of the federal poverty guidelines, and the Pool should pursue other sources of funding for premium subsidies.**

***Small Employers:*** Small employers are much less likely to offer health insurance to their employees than larger firms. This is due, in part, to higher premium costs faced by small employers. In North Carolina in 2005-2006, firms with fewer than 50 employees paid, on average, $313 more for premiums than firms with 50 or more employees.[13] Higher premiums for small employers are largely due to higher administrative loads, more volatile risk, and a higher risk for adverse selection.[14] The Study Group examined several strategies for reducing the number of low-income uninsured workers in small firms, including modifying the small group rating laws to eliminate groups of one from the small group market and using public subsidies to lower the cost of health insurance for small employers. A summary of the Study Group's recommendations on small employers is listed below. The full text of the recommendations is available in Chapter 6.

## 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 would impact small group rates and the number of people with insurance coverage.**

## Recommendation 6.2

**The North Carolina General Assembly should provide tax subsidies or otherwise subsidize the cost of health insurance premiums for small employers. Funding should be targeted to firms with 15 or fewer eligible employees, at least 30% of whom are low-wage workers. The North Carolina General Assembly should provide subsidies that will reduce total premiums by 30% for low-wage workers.**

***The Safety Net:*** Non-profit safety net organizations in North Carolina are committed to providing free or reduced-cost care to the low-income uninsured. Many of these organizations provide preventive and primary care as well as chronic disease management, while others provide more specialized services. Although these organizations exist across the state, many have neither the funding nor the capacity to care for the growing number of uninsured. In 2005, the North Carolina General Assembly created the Community Health Center Grants program to expand the safety net infrastructure.[15] The majority of funding has been non-recurring. Safety net organizations need recurring funding to expand their capacity to serve the growing number of uninsured. In addition, care received at safety net organizations is often fragmented. Communities can provide more effective care and address more of the needs of the uninsured by developing systems of care that include specialty services, diagnostic services, hospitalization, medications, and disease and care management (i.e. community collaborations). Continued funding of HealthNet, a program supporting the development of community collaborations for the uninsured, is necessary to increase community collaborations and continuity of care for the uninsured.

## Recommendation 7.1 (PRIORITY RECOMMEDNATION)

**The North Carolina General Assembly should appropriate $8 million in recurring funds to the Office of Rural Health and Community Care to expand the safety net infrastructure (Community Health Center Grants program), and $2.2 million in new recurring funds to support community collaborations of care for the uninsured (HealthNet).**

**The state is likely to experience a shortage of physicians, nurse practitioners, and physician assistants in the next 10-20 years.**

***Provider Supply:*** In order to ensure access to health care, the state must also ensure there is a sufficient number of health care professionals to meet the future health care needs of North Carolinians. Due to time restraints, the Health Access Study Group could not thoroughly examine all health professional workforce issues. Instead, the Study Group focused on the supply of physicians, nurse practitioners, and physician assistants. The state is likely to experience a shortage of these providers in the next 10-20 years, measured in the provider-to-population ratio.[16] This shortage is due to the combination of an increased demand for services (due to the growth and aging of the population and increase in the number of people with chronic illnesses) and a decline in the number of practicing professionals (as a large cohort of professionals reach retirement age).[16] North Carolina may experience more severe shortages within certain types of specialties, including primary care, general surgery, psychiatry, and professionals who deliver babies. In addition, there is already a maldistribution of providers across the state, as well as a shortage of minority health professionals. The maldistribution problem is likely to be exacerbated as the overall supply declines. The Study Group made a number of recommendations to increase provider supply. The summary of the recommendations is included below. The full text is included in Chapter 8.

## Recommendation 8.1

**The North Carolina General Assembly should appropriate $40 million in recurring funds to support the expansion of medical schools at the University of North Carolina and East Carolina University. The North Carolina General Assembly should appropriate $1.2 million in recurring funds and/or Medicaid Graduate Medical Education, over the next five years, to the North Carolina Area Health Education Centers to fund 12 new residency positions per year targeted toward the high priority specialty areas of primary care, general surgery, psychiatry, or other specialty shortage areas. The North Carolina General Assembly should direct the University of North Carolina System to explore further expansion of physician assistant and nurse practitioner programs.**

## 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 continue to support the Community Care of North Carolina network, continue to tie Medicaid reimbursement to physicians at 95% of the Medicare rate, and direct the Division of Medical Assistance to increase the payment for primary care practitioners practicing in health professional shortage areas. The North Carolina General Assembly should appropriate $1,915,600 million in recurring funds in SFY 2010 to the North Carolina Office of Rural Health and Community Care for technical assistance for practices in underserved areas, financial incentives for professionals practicing in underserved areas, and recruitment efforts.**

## Recommendation 8.3

**In order to expand the health professional workforce in underserved areas of the state, the North Carolina General Assembly should direct the North Carolina Office of Rural Health and Community Care 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 North Carolina General Assembly should also continue to support existing programs to enable them to work with practices in underserved areas to assist with systems redesign and quality improvement initiatives.**

## Recommendation 8.4

**The North Carolina General Assembly should appropriate $250,000 in SFY 2010 in recurring funds to the North Carolina Office of Rural Health and Community Care (ORHCC) to support technical assistance provided through ORHCC and the North Carolina Medical Society Foundation PracEssentials programs. 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. Additionally, 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 business skills.**

North Carolinians face many challenges in accessing high quality, affordable health care. Those without health insurance face some of the most daunting challenges, but even those with health insurance are facing increasing barriers to accessing health care services. Rising health care costs affect everyone—those with and without insurance coverage. Further, the lack of health care professionals in some areas of the state and the expected decline in the number of health professionals portends even worse health access problems in the future. Addressing these problems will require a multifaceted approach mixing public and private coverage strategies, increased support for the health care safety net, and investments in the health professional workforce. Ultimately, everyone stands to benefit from improved health care access, and everyone—individuals, families, employers, and government—have a role to play in designing and implementing the solutions. Although solutions are not always easy or inexpensive, like so many other public policy issues, a deliberate, stepwise approach—beginning immediately—will be more successful than waiting until the system collapses.

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