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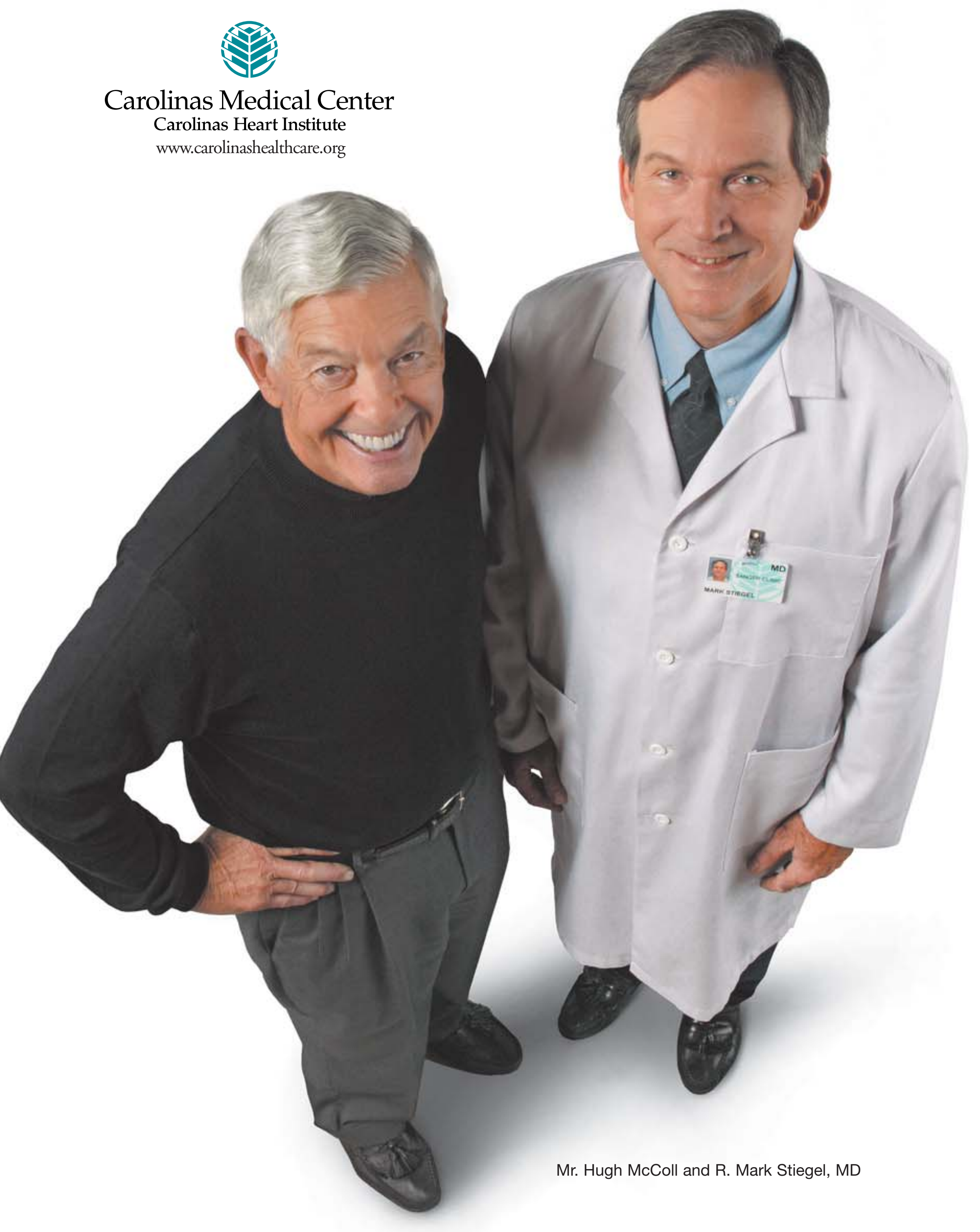

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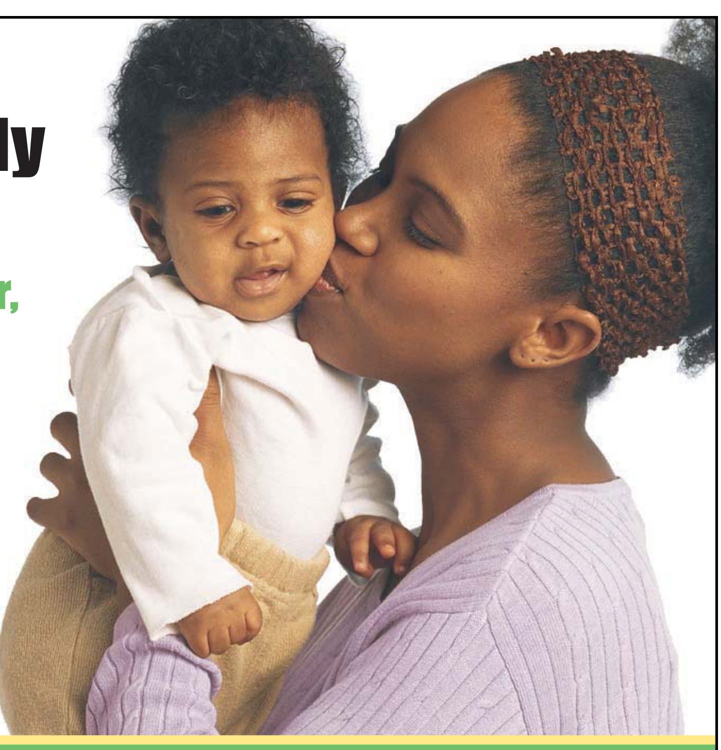

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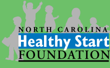

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North Carolina
MEDICAL JOURNAL
a journal of health policy analysis and debate

May/June 2006, Volume 67, Number 3 **Published by the North Carolina Institute of Medicine and The Duke Endowment**

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"The uninsured delay needed healthcare services, and as a result, are more likely to be diagnosed with severe health problems. Those with chronic diseases are less likely to receive the care they need to control their conditions."

Tarheel Footprints in Healthcare

Recognizing unusual and often unsung contributions of individual citizens who have made healthcare for North Carolinians more accessible and of higher quality

Recognizing Shirley Lucey and Virginia Scanlan and the Alice Aycock Poe Center for Health Education

Without the volunteer efforts of many of our state's citizens, North Carolina would not be the envy of so many others. Dozens of the wonderful programs and organizations for which this state is known sprang from the ideas, commitment, and determination of a few individuals who saw a need, convinced others of the feasibility of addressing it, and then led the effort to mobilize the resources to make a valuable initiative possible.

Such is the case with what is now known as the Alice Aycock Poe Center for Health Education in Raleigh, a statewide non-profit organization whose mission is to provide comprehensive programs and resources in healthy lifestyle education for all youth in North Carolina. This wonderful facility offers on-site instruction to more than 5,500 school-age participants each year, coming from many school districts throughout North Carolina. The Poe Center's theatre-style instructional programs are delivered by master teachers to classes of students from across the state who come to the Center for periods of a few hours or a whole instructional day. Classes are conducted in model classrooms, which are exceptionally well-equipped as teaching theaters dealing with: general health, nutrition, physical activity, dental health, drug education, and family life and reproductive health.

The Poe Center was first imagined as filling a need in the Wake County Schools, initially as an exhibit at the old North Carolina Museum of Natural History funded by the Wake County Medical Society Auxiliary. When the new museum was built, space for a health-focused exhibit was limited so members of the Auxiliary started exploring other educational program possibilities. Leaders of the organization decided to visit eight-to-ten free-standing health education centers around the nation to see how these facilities and programs operated and whether this idea might be feasible in central North Carolina. The result was a decision to start raising funds to construct a multi-classroom teaching facility, which could become a resource for all schools and school systems in North Carolina, thus extending the impact of regular classroom instruction on matters related to health and enlivening the content and presentation style associated with this information.

The two individuals who took primary responsibility for conceptualizing the Poe Center's program and for raising the funds to support its implementation, including its physical construction, were **Shirley Lucey** and **Virginia Scanlan**, who served as President of the Board of Directors of the Poe Center in 1987-1988 and 1988-1989, respectively. Ms. Lucey and Ms. Scanlan organized teams of their Wake County Medical Auxiliary colleagues in 1990 to approach dozens of corporate and individual donors, and they worked with area school systems to develop contracts with the Poe Center for the instructional programming that would be offered. Their efforts raised the $3.5 million necessary to build this fabulous teaching/learning facility and are a tribute to their dedication and determination. "Once the first $100,000 was raised, there was no turning back," Virginia Scalan recently recalled. Most of the counties in central North Carolina and beyond have benefited from their efforts as the Poe Center has taken shape. Today, the Poe Center offers programs of instruction for students from some 25 school systems throughout North Carolina, as well as special programs of teacher training, educational programs focused on specific disease and public health issues (e.g., breast cancer, family life, adolescent health, substance abuse, dental health), and active summer programs for children from preschool to age ten. Shirley Lucey recently gave credit to the physician members of the Wake County Medical Society, who collectively donated $1 million of the total cost of building this facility. The footprints of these leading Tarheel volunteers have made a deep impression on the lives and health of North Carolina's children.

Shirley Lucey (left) and Virginia Scanlan (right) inside the Alice Aycock Poe Center for Health Education

ARTICLE

Support for Tobacco Control Policies among Youth in North Carolina

Elizabeth Conlisk, PhD, Scott K. Proescholdbell, MPH, and William K.Y. Pan, DrPH

Abstract

Background: *The objective of this research was to examine attitudes toward tobacco control policies among middle and high school students in North Carolina. Specifically, we report data on knowledge of the harmfulness of secondhand smoke and support for restaurant and school-based smoking restrictions.*

Methods: *The statewide North Carolina Youth Tobacco Survey was administered to a representative sample of 3,073 middle school and 3,261 high school students in the fall of 2003. The overall response rate for the middle and high school samples was 77.0% and 77.4%, respectively. Support for tobacco policies was analyzed by smoking status and by knowledge of the harmfulness of secondhand smoke*

Results: *The vast majority of respondents in the middle school (87.6%) and high school (91.6%) reported that secondhand smoke was "definitely" or "probably" harmful. However, less than half of middle school (48.6%) and high school (40.2%) students responded that smoking should be banned in restaurants. Even among the select group of students who had never smoked and who believed secondhand smoke was harmful, support for such a ban was less than 60% at both school levels.*

Conclusions: *Youth in North Carolina are aware of the health risks of secondhand smoke, but are not convinced of the need to restrict smoking in restaurants. These results point to the need for more youth-focused advocacy and education around smoking restrictions, both to reduce youth exposure to secondhand smoke and to solidify voter support for such protections once they reach adulthood.*

Key words: *youth, tobacco control, smoking restrictions.*

Introduction

Over the past 20 years, exposure to secondhand smoke (SHS) has been associated with an increased risk of lung cancer, heart disease, and respiratory ailments in non-smokers and has been estimated to cause approximately 3,000 lung cancer deaths and 35,000 heart disease deaths in adult non-smokers in the United States each year.[1,2] In addition, SHS has been associated with adverse infant outcomes, such as low birth weight and Sudden Infant Death Syndrome, as well as childhood asthma and middle ear infections.[3] As awareness of the health risks of SHS has increased, so has support for policies that restrict smoking in public places such as restaurants, where SHS levels have been found to be two-to-five times higher than levels in the homes of smokers.[4] From 1992 to 1999, support for smoking bans in restaurants increased from 37.5% to 59.8% among adults in Massachusetts.[5] Unfortunately, not all states show majority support for such bans. A recent report compared the results of 20 statewide surveys on attitudes toward tobacco control policies in 2000.[6] In four of those states, less than half of the respondents favored policies to ban smoking in restaurants; support was lowest in North Carolina (44%), the largest tobacco producing state in the country.

As opposed to most adults, today's adolescents are growing up in an era when the risks of SHS are well established and smoking restrictions are not uncommon. Even in North Carolina, local smoking regulations were hotly debated and adopted in more than 100 municipalities/counties before a statewide preemption bill went into effect in 1993.[7] In addition, North Carolina has an active tobacco education and prevention

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program in the schools, and more than 80% of middle and high school students responded that SHS was harmful to non-smokers in a 1999 survey.[8] However, it is unclear whether that knowledge translates into stronger support for smoking restrictions among adolescents and whether they might be expected to solidify public support as they come into adulthood.

To our knowledge, few studies have examined attitudes toward tobacco control policies among youth,[9-12] and only two have examined support for smoking bans in restaurants. Albers et al.[11] reported that support for restaurant bans among Massachusetts youth in 2001-2002 ranged between 53% and 61%, depending on the strength of local restrictions on smoking in restaurants. Support was similar among adolescents in metropolitan Ohio, with 56% agreeing that smoking should not be allowed in restaurants without bars.[12] Our report adds to these findings by examining knowledge of SHS risk and support for restaurant bans among middle and high school students in North Carolina where there is relatively low adult support. As support for restaurant bans has been shown to vary by smoking status in adults[8] and youth,[11] data will be reported separately for current smokers and those who have never smoked. Support will also be analyzed by knowledge of the harmfulness of SHS, an analysis not previously reported.

Methods

Data were collected through the school-based North Carolina Youth Tobacco Survey (YTS) in the fall of 2003. Details of the YTS methodology used nationally have been described elsewhere.[13] In brief, the North Carolina Youth Tobacco Survey used a two-stage cluster sample design to produce a representative sample of public middle school (grades 6-to-8) and high school (grades 9-to-12) students. Sampling was stratified by region to assure a balanced representation of schools from the coastal, piedmont, and mountain areas.

The first-stage sampling frame consisted of all public schools (including charter schools) that included at least one grade between 6 and 12. Schools were selected with a probability proportional to school enrollment size. The second sampling stage consisted of systematic equal probability sampling of second-period classes in each school sampled. An average of three second-period classes was sampled per school. All students in the sampled classes were eligible to participate in the survey except those who are routinely exempt from written tests because of language or learning barriers. Participation was voluntary and anonymous, and school procedures for parental permission were followed. The overall response rate for the middle and high school samples was 77.0% and 77.4%, respectively. Non-participation was primarily due to absenteeism. The final sample included 3,073 students from 104 middle schools and 3,261 students from 96 high schools.

The self-administered, 78-item questionnaire included questions on tobacco use, SHS, and attitudes toward tobacco policies. The specific questions asked about SHS are given at the bottom of Table 1. Responses are reported for the total sample and for two subgroups defined by smoking status: current smokers and never smokers. Respondents who reported smoking within the past 30 days were classified as current smokers. Respondents who reported having never smoked a cigarette were classified as never smokers. The comparison of current versus never smokers intentionally omits former smokers to heighten the contrast based on smoking status; hence the number of current smokers and never smokers will be less than the totals reported in the table. All percentages reported are weighted to reflect the likelihood of sampling each student and to compensate for differing patterns of non-response. SUDAAN was used to compute variance estimates and 95% confidence intervals.[14]

Results

Among middle school students, 9.3% (95% CI 7.7 to 10.9) were classified as current smokers and 70.5% (95% CI 66.5 to 74.5) as never smokers. Among high school students, 27.3% (95% CI 24.0 to 30.6) were classified as current smokers and 40.4% (95% CI 36.3 to 44.5) as never smokers.

Middle school students were slightly less likely than high school students to believe that SHS was harmful, although the percentage for both groups was quite high, 87.6% (95% CI 85.3 to 89.9), and 91.6% (95% CI 90.0 to 93.2), respectively) (see Table 1). Current smokers were less likely than never smokers to respond that SHS was harmful, but the percentage that did was still high for both middle school (83.1%, 95% CI 77.3%, 88.9) and high school (85.1%, 95% CI 81.4 to 88.8) students. Less than half of middle school (48.6%, 95% CI 45.8 to 51.4) and high school (40.2%, 95% CI 37.0 to 43.4) students responded that smoking should be banned in restaurants. Support for smoke-free restaurants was much higher among those who had never smoked compared to current smokers: 55.4% (95% CI 51.4 to 58.4) vs. 22.6% (95% CI 15.0 to 30.2) at the middle school level and 58.8% (95% CI 55.0 to 62.6) versus 16.1% (95% CI 11.6 to 20.6) at the high school level. Similar data and trends were observed for the question on personal preference for smoke-free space. Support was much higher for the adoption of tobacco-free policy at schools—91.8% (95% CI 90.4 to 93.2) of middle school students and 75.5% (95% CI 72.5 to 78.5) of high school students favored such policies. Even among current smokers, there was majority support for tobacco-free school policies in both the middle schools (68.8%, 95% CI 60.6 to 77.0) and high schools (51.1%, 95% CI 55.6 to 56.6).

Support for tobacco control policies among never smokers tended to be higher among students who believed SHS was harmful (see Table 2). Still, support for smoking bans in restaurants at the middle or high school level never reached 60%, even among the select group of students who had never smoked and who believed SHS was harmful. Similarly, only 61.4% (95% CI 57.9 to 64.9) (middle school) and 54.2% (95% CI 50.1 to 58.3) (high school) of this select group stated that they preferred to eat in smoke-free restaurants. In contrast, support for tobacco-free schools was considerably higher in this group—96.6% (95% CI 95.6 to 97.6) and 89.7 (95% CI 86.3 to 93.1) for the middle and high school, respectively. Among current smokers,

Table 1.
Knowledge of the Harmfulness of Secondhand Smoke (SHS) and Support for Tobacco Control Policies among Middle and High School Students, North Carolina, 2003

		Middle School		High School	
		n	% (95% CI)	n	% (95% CI)
Believe SHS is harmful[1]	All*	2,934	87.6 (±2.3)	3,211	91.6 (±1.6)
	Current smokers	268	83.1 (±5.8)	861	85.1 (±3.7)
	Never smokers	1,927	88.6 (±2.6)	1,226	95.5 (±1.8)
Think smoking should be banned in restaurants[2]	All	2,901	48.6 (±2.8)	3,191	40.2 (±3.2)
	Current smokers	269	22.6 (±7.3)	854	16.1 (±4.5)
	Never smokers	1,896	55.4 (±3.0)	1224	58.8 (±3.8)
Prefer smoke-free restaurants[3]	All	2,882	53.0 (±3.1)	3,169	39.5 (±2.3)
	Current smokers	271	23.6 (±7.8)	851	18.9 (±4.2)
	Never smokers	1,874	60.0 (±3.6)	1,212	53.3 (±3.8)
Think it is important for school to be 100% tobacco-free[4,5]	All	2,547	91.8 (±1.4)	2,735	75.5 (±3.0)
	Current smokers	226	68.8 (±8.2)	726	51.1 (±5.5)
	Never smokers	1,679	95.9 (±1.0)	1,040	89.3 (±3.3)

1 Responded "Definitely yes" or "Probably yes" to the question "Do you believe the smoke from other people's cigarettes is harmful to you?"

2 Responded "Not allowed at all" to the question "In restaurants, to what extent do you think that smoking should be allowed?"

3 Responded "I prefer places where no smoking is allowed" to the question "When you go out to a place with your friends and family, what smoking policy do you prefer?"

4 Responded "Very important" or "Somewhat important" to the question "In your opinion, how important is it that your school district adopt a "100% tobacco-free school policy?"

5 Students who responded that their district was already 100% tobacco-free were omitted from the analysis.

The data collection protocol was approved by the Centers for Disease Control and Prevention and the research protocol was approved by the institutional review board at Hampshire College.

* All includes current, former, and never smokers. Details are only given for current and never smokers.

support for tobacco control policies was associated with SHS knowledge at the middle school level, but the confidence intervals were quite wide. Among current smokers at the high school level, knowledge appeared to have little impact on support for tobacco control policies.

Discussion

This paper is the first to examine support for restaurant- and school-based tobacco control policies among youth in a major tobacco-growing state. The results are mixed. Knowledge is high, with approximately nine of ten middle and high school students reporting that SHS is harmful to non-smokers. These results are comparable to those reported in the 2000 National Youth Tobacco Survey,[12] suggesting that North Carolina youth are as informed about the risks of SHS as youth nationally. Also, approximately nine of ten middle school students and three of four high school students supported the adoption of a 100% tobacco-free policy in their school districts. This latter analysis excluded the 11% (middle school) and 14% (high school) of students who responded that their district had already adopted such a policy, districts that presumably are more supportive of tobacco control measures in schools. Hence, the overall support for such a policy is probably even greater.

Support for bans on smoking in restaurants, however, was much less common. Less than half of students supported such bans, and support was no greater than that reported by North Carolina adults surveyed in 2000 (44%).[6] It is unclear why support among youth is not greater, given the high awareness

Table 2.
Support for Tobacco Control Policies among Middle and High School Students, by Knowledge of the Harmfulness of Secondhand Smoke, North Carolina, 2003

		Middle School				High School			
		Believes SHS is harmful[1]		Does not believe SHS is harmful		Believes SHS is harmful[1]		Does not believe SHS is harmful	
		n	% (95% CI)	n	% (95% CI)	n	% (95% CI)	n	% (95% CI)
Think smoking should be banned in restaurants[2]	All*	2,541	50.7 (±3.1)	342	34.1 (5.7)	2,905	41.8 (3.0)	263	23.9 (9.6)
	Current smokers	207	25.0 (±8.3)	56	12.5 (±9.9)	714	16.7 (±5.1)	126	13.1 (±8.2)
	Never smokers	1,703	57.2 (±3.7)	191	40.7 (±8.6)	1,165	59.8 (±4.2)	55	40.7 (±21.2)
Prefer smoke-free restaurants[3]	All	2,521	54.4 (±3.2)	344	43.8 (±7.3)	2,889	40.7 (±2.6)	261	27.0 (±7.2)
	Current smokers	208	24.1 (±9.8)	57	24.4 (±18.0)	712	19.6 (±4.8)	127	15.4 (±8.7)
	Never smokers	1,682	61.4 (±3.5)	190	48.8 (±8.7)	1,155	54.2 (±4.1)	54	34.1 (±23.2)
Think it is important for school to be 100% tobacco-free[4,5]	All	2,239	93.6 (±1.4)	289	80.3 (±5.2)	2,487	77.0 (±3.0)	229	60.0 (±7.2)
	Current smokers	170	72.7 (±8.5)	50	52.0 (±19.6)	603	51.8 (±6.0)	112	48.6 (±10.6)
	Never smokers	1,513	96.6 (±1.0)	163	89.7 (±5.5)	993	89.7 (±3.4)	44	78.5 (±15.3)

1 Responded "Definitely yes" or "Probably yes" to the question "Do you believe the smoke from other people's cigarettes is harmful to you?"

2 Responded "Not allowed at all" to the question "In restaurants, to what extent do you think that smoking should be allowed?"

3 Responded "I prefer places where no smoking is allowed" to the question "When you go out to a place with your friends and family, what smoking policy do you prefer?"

4 Responded "Very important" or "Somewhat important" to the question "In your opinion, how important is it that your school district adopt a "100% tobacco-free school policy?"

5 Students who responded that their district was already 100% tobacco-free were omitted from the analysis.

The data collection protocol was approved by the Centers for Disease Control and Prevention and the research protocol was approved by the institutional review board at Hampshire College.

* All includes current, former, and never smokers. Details are only given for current and never smokers.

of the risks of SHS and strong support for tobacco-free policies in schools (policies which are actually more restrictive as they apply to all tobacco use, and not just cigarettes). This apparent inconsistency could be due to a number of factors. Perhaps youth are aware of the risks of SHS, but do not perceive these risks as serious. Similarly, youth might view restaurants, unlike schools, as voluntary, short-term exposures and not as daily worksites for restaurant staff. Thus, they might not see the need for government regulation of what appears to be a voluntary risk.

It is also possible that these attitudes reflect the hard work of the school-based tobacco control programs, which have focused their advocacy work on the adoption of tobacco-free policies in school districts. These efforts appear to have been successful, both in the overwhelming support among youth for such policies and the tripling of tobacco-free school districts in the past two years—from 15 at the start of 2003 to 45 by the end of 2004. In contrast, less emphasis has been placed thus far on tobacco use in public places, such as restaurants. The results here point to the need for school-based advocacy around this issue as well, both in reducing youth exposure to SHS and helping to solidify voter support for such protections once they reach adulthood.

The percentage of students who prefer to patronize smoke-free restaurants is not much higher than those who support bans. Even among never smokers who are aware of SHS risks, only a modest majority prefers smoke-free space. As with tobacco use itself, knowledge is not sufficient for avoiding risk. This finding supports the innovative work of Albers et al., who examined the acceptability of smoking in restaurants to youth in Massachusetts relative to social norms, as measured by community-level smoking restrictions.[11] While the relationship between acceptability and community-level restrictions was not statistically significant, it was in the hypothesized inverse direction (acceptability

declined as restrictions increased), which underscores the importance of social norms in both research and advocacy education at the school level. In this research, we attempted to examine support for tobacco control policies by tobacco-free school status; however, too few districts had implemented such policies at the time of this survey for a meaningful analysis. As we continue tracking support for tobacco control policies in the biannual YTS in North Carolina, we will broaden our analysis to include information about community-level norms as reflected by school-based policies. In tobacco-producing states such as North Carolina, analysis and policy may further benefit from the use of geographic mapping software to target interventions where tobacco use is high. We also encourage the Youth Tobacco Survey coordinators in other states to add questions on tobacco control policies so that such policies can be tracked and responded to nationally. **NCMedJ**

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Covering the Uninsured

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"Most of the increase in the uninsured is due to the drop in employer-sponsored insurance. North Carolina experienced a greater loss in employer-sponsored insurance than other states."

INTRODUCTION

Policy Forum:
Covering the Uninsured

More than 1.3 million North Carolinians have no health insurance, and these numbers are growing more rapidly in our state than in other states. As a result, the overall health of North Carolina suffers—the uninsured experience poorer health and miss more days of work and school; our healthcare institutions face financial strain; and those with insurance pay higher health insurance premiums as costs are shifted. Who are these people—the uninsured? Some may be surprised to learn that 78% of them work full-time jobs or live in a family where at least one person has a full-time job. Not surprising is that many people without insurance have incomes below 200% of the federal poverty guidelines.

To address this problem, the North Carolina Institute of Medicine, in collaboration with the North Carolina Department of Health and Human Services (NC DHHS), the North Carolina Department of Insurance, and the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill, convened a Task Force to study options that would expand health insurance coverage to more North Carolinians. They released their report and recommendations in April 2006. In this issue of the Journal, we highlight some of Task Force's work and provide further discussion through commentaries written by some of the Task Force members and other stakeholders.

The commentaries examine issues faced by: small employers providing health insurance coverage; physicians, dentists, and hospitals providing care to the uninsured, and state government officials who regulate the insurance industry and provide public health insurance via Medicaid. We also include discussions on why healthcare costs are increasing, strategies for controlling these costs, strategies for promoting legislative change, policy options for small employers and high-risk pools, and how the problem of lack of insurance manifests itself among our state's growing Latino population.

The Task Force was chaired by Carmen Hooker Odom, Secretary of the NC DHHS, and Thomas Lambeth, former Executive Director of the Z. Smith Reynolds Foundation. Under their leadership, the Task Force realized it could not develop a plan that would provide coverage for all who needed it, but believed a multi-pronged approach could be developed to help large numbers of the uninsured. They were further guided by the belief that everyone in North Carolina will benefit if more people have health insurance coverage. As more people gain health insurance coverage, they also gain needed access to healthcare and better health. Having healthier citizens in our state will lead to lower healthcare costs and insurance premiums, higher worker productivity, better school attendance, financially more secure healthcare institutions, and, ultimately, a stronger economic future. Ideally, all North Carolinians should have health insurance that meets their basic healthcare needs, but until this is possible, the recommendations found in the Task Force report would help expand coverage to thousands.

We hope this issue of the Journal helps bring greater understanding to a complex and painful problem for our state. North Carolina is fortunate to have a group of stakeholders willing to work together toward a solution. The collaborative efforts of this Task Force increase the likelihood for change and provide hope for new policy and a healthier North Carolina.

Gordon H. DeFriese, PhD
Editor-in-Chief

Kristie W. Thompson, MA
Managing Editor

ISSUE BRIEF

North Carolina's Uninsured

Pam Silberman, JD, DrPH, Carmen Hooker Odom, MRP, Thomas Lambeth, G. Mark Holmes, PhD, and Kristen L. Dubay, MPP

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

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

"Workers who are in poor health are less productive, children who are sick miss more days of school, and the growing numbers of uninsured are creating an economic strain on the healthcare institutions that care for everyone."

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

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

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

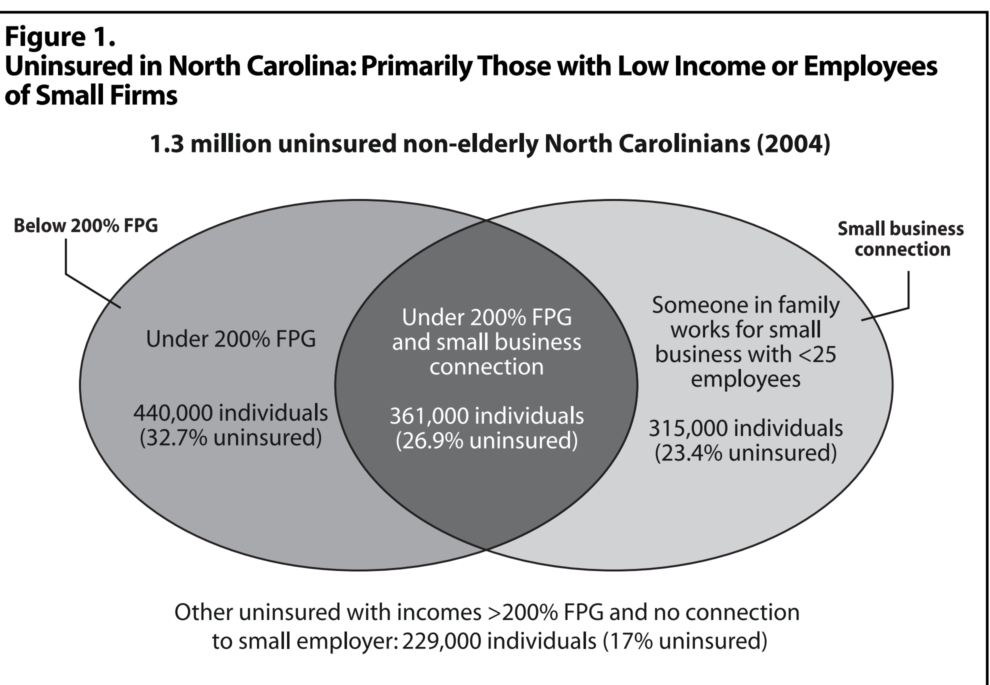
People who lack insurance coverage have a harder time obtaining needed healthcare, and as a consequence, their health suffers. But the rising numbers of uninsured have broader societal implications. Workers who are in poor health are less productive, children who are sick miss more days of school, and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

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

The Demographics of the Uninsured

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

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



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

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

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

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

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

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

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

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

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

Health Effects of Being Uninsured

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

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

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

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

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

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

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

Rising Healthcare Costs Are Leading to the Increased Numbers of Uninsured

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

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

Employers have responded to these rising premium costs by

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

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

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

Incremental Reform Efforts

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

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

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

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

Expand the Healthcare Safety Net

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

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

Promoting Personal Health Responsibility to Improve Population Health

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

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

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

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

Low-cost Health Insurance Product for Small Employers

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

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

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

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

Limited-Benefit Health Insurance Product for Low-Income Parents

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

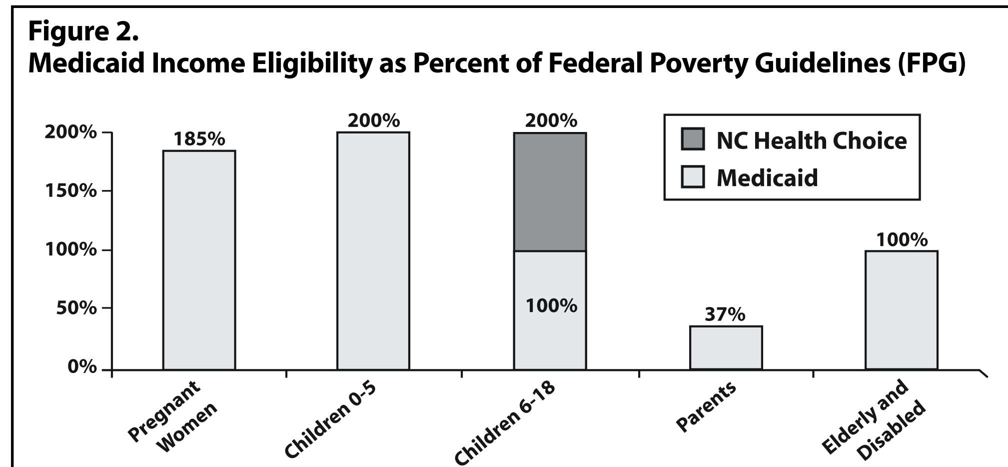
e Reinsurance is essentially insurance coverage for insurance carriers. If the annual claims for an individual in the plan reach some predetermined amount, then the reinsurer covers at least some part of the claims above that level. Under the Healthy New York program, the state reimburses private health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

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

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

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

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



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

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

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

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

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

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

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

Conclusion

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

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

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

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COMMENTARY

Healthcare Costs:
The Engine Driving the Decline in Insurance

Sandra B. Greene, DrPH

The increase in the percent of the population that is uninsured in both North Carolina[1] and across the nation[2] is driven by the increasing costs of health insurance premiums. Nationally, health insurance premiums increased 65% between 2000 and 2004. This rise was more than six times greater than general inflation (9.7%), and more than five times the wage growth (12.2%).[3] The increase in premiums makes it harder for employers to offer insurance to employees and for individuals to purchase healthcare coverage. Research indicates that for every 10% increase in health insurance premiums, the number of firms that offer health insurance to their employees falls by roughly 2.5%.[4]

Most of the increase in health insurance premiums is due to the increase in the underlying costs of healthcare.[5,6,7,8] Healthcare costs increase for a variety of reasons, some due to the increased cost of individual services, some due to greater utilization of services, and some due to changes in overall disease prevalence. This commentary examines trends in personal healthcare spending in North Carolina between 1990 and 2000, changes in unit costs and utilization of different services, and the effects of changes in disease prevalence and demographic changes on healthcare spending. The commentary concludes with how these changes impact health insurance premiums and how employers and individuals respond to rising premium costs.

Total Personal Healthcare Spending in North Carolina (1990-2000)

Data from the Office of the Actuary of the federal Centers for Medicare and Medicaid Services show that North Carolinians spent $31.3 billion dollars on personal healthcare expenses in 2000.[9] Table 1 shows how the dollars were spent and the increases in expenditures by service type between 1990 and 2000 (the most recent data available).

In 2000, more than one third of personal health spending in

Table 1.
Per Capita Personal Healthcare Expenditures, North Carolina, 1990, 2000

Healthcare Services or Products	1990	1990 % of total	2000	2000 % of total	% Increase 1990-2000
Hospital Care	$5,905	42.8%	$12,060	38.6%	104.2%
Physician and Other Professional Services	$3,748	27.2%	$8,025	25.7%	114.1%
Dental Services	$662	4.8%	$1,508	4.8%	127.8%
Home Healthcare	$288	2.1%	$1,150	3.7%	299.3%
Prescription Drugs	$1,110	8.0%	$3,882	12.4%	249.7%
Other Non-Durable Medical Products (e.g., diabetes test strips)	$546	4.0%	$679	2.2%	24.4%
Durable Medical Products (e.g., wheelchairs or walkers)	$215	1.6%	$477	1.5%	121.9%
Nursing Home Care	$1,115	8.1%	$2,524	8.1%	126.4%
Other Personal Healthcare	$208	1.5%	$979	3.1%	370.7%
Total	*$13,797*	*100.0%*	*$31,284*	*100.0%*	*126.7%*

Figures are in millions
Source: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. North Carolina Personal Health Care Expenditures (PHCE), All Payers 1980-2000.

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North Carolina was spent on hospital care (39%), and approximately one quarter (26%) on physicians and other professional services.[9] These expenditure rates are similar to those at the national level (36% and 29%, respectively) and accounted for more than half of the increase in total expenditures from 1990-2000. Hospital care accounted for 35% of the increase in spending, while physician and other professional services accounted for 25%. However, in recent years, prescription drugs have been one of the fastest growing components of healthcare spending. Prescription drugs accounted for 16% of the increase in overall healthcare spending between 1990 and 2000. As a result, prescription drugs constituted 12% of North Carolina's personal healthcare expenditures in 2000, compared to 8% in 1990.[a,9] Long-term care (home health and nursing care) also constituted 12% of North Carolina's personal healthcare expenditures in 2000, with spending on home healthcare increasing more than 300% since 1990.[b]

Changes in Unit Cost and Utilization of Different Services

Expenditures for healthcare services are a function of two components: price per unit of service and the number of units (amount of services received). Understanding whether the price or use of a service is increasing, or both, can help policymakers determine how to respond to healthcare cost increases. As described in more detail below, an increase in unit costs explains the rising costs of hospital inpatient care, while increased utilization explains the rising costs of hospital outpatient services and technology (particularly imaging). For prescription drugs, there has been both an increase in utilization and unit costs.[10]

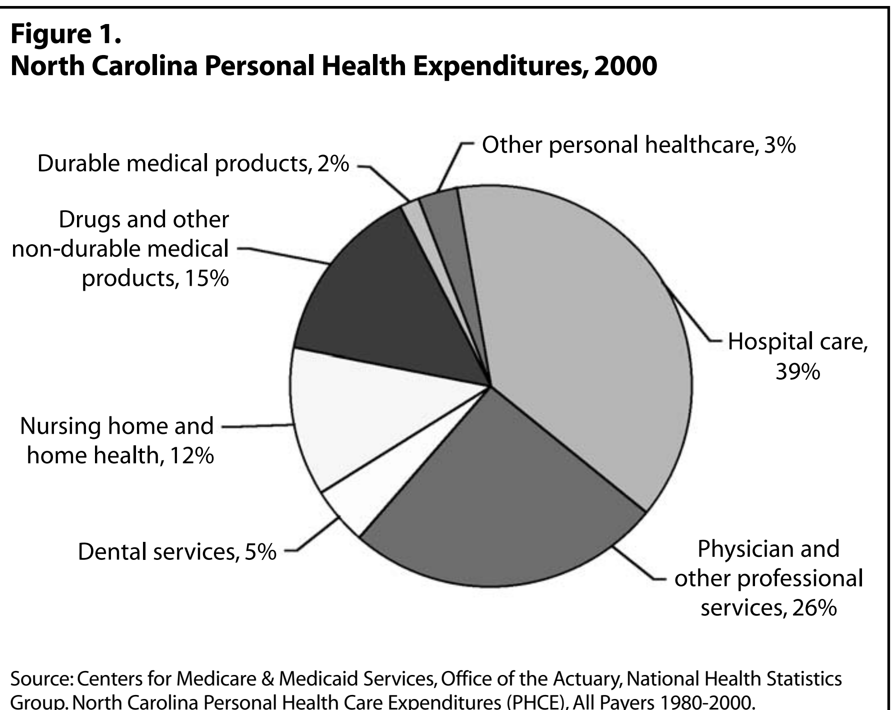
Previous efforts to curb rising costs of care have focused primarily on price because it is easier to address what something costs than to manage its utilization. Providers contribute to increased utilization, as changes in technology or treatment protocols lead to increased use of certain services or procedures. Defensive medicine—or ordering unnecessary tests or procedures to prevent a potential malpractice claim—also increases utilization. Consumers' demand for services and medications also contributes to rising healthcare utilization. Controlling utilization is generally more difficult than trying to control costs because the public often views the former as restrictions on accessing needed healthcare.[11] However, recent strategies have designed consumer cost-sharing to influence patient utilization rates. By placing more financial responsibility on consumers, patients may reduce their use of marginally useful or unnecessary healthcare services.[c,12]

Hospital Care

Between 1990 and 2000, hospital spending increased 104% in North Carolina (see Table 1) and accounted for 35% of total growth in personal healthcare expenditures. Hospital spending includes that spent on both inpatient and outpatient services. More recent national data showed that hospital inpatient spending increased 6.2%, while hospital outpatient spending increased 11.3% between 2003 and 2004.[13]

The increase in hospital services expenditures is due primarily to an increase in unit price, rather than an increase in utilization. Nationally, hospital utilization increased only 2.9% in 2004, but hospital unit costs for inpatient and outpatient services combined increased 7%.[13] On a population basis, North Carolinians are spending less time as inpatients than a decade ago. In 1989, North Carolina residents' utilization of inpatient hospital services was 752 days per 1,000 persons, compared to

Figure 1.
North Carolina Personal Health Expenditures, 2000



Source: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. North Carolina Personal Health Care Expenditures (PHCE), All Payers 1980-2000.

a Prescription drugs, by themselves, constituted 12.4% of personal healthcare expenditures in North Carolina in 2000; non-durable medical products amounted to another 2.2% of the state's personal healthcare expenditures.[9]

b Long-term care expenditures, unlike most other healthcare expenses, are highly dependent on the payer. Public insurance programs, such as Medicare and Medicaid, account for a substantial portion of total spending on long-term care.

c The most notable work in this area stems from the RAND Health Insurance Experiment conducted in the late 1970s. Utilization was lower in plans that had greater cost sharing, but there was mixed evidence on whether the healthcare services were necessary. Health status for most people was unaffected by their reduced services, but for the sick and poor, health was adversely affected.

only 542 days per 1,000 in 2003.[14] The most dramatic decline in utilization occurred among the elderly population.

By contrast, the cost per day spent in the hospital or per admission is escalating because there are more services, treatments, and procedures provided to patients once they enter the hospital. In addition, as more non-emergent healthcare needs can be treated on an outpatient basis, inpatient utilization for those services decreases, and the more intensive, higher-cost services account for a greater proportion of inpatient services, which raises costs. Further, hospital labor costs for nursing and other healthcare professionals have increased.[15,16]

Costs for hospital outpatient care are also increasing as the result of both higher utilization and greater unit price.[13] This increase is a reflection of more services and procedures, such as biopsies, surgeries, and chemotherapy, which are now safe and acceptable when performed on an outpatient basis. In the past, some of these services would have been performed solely on an inpatient basis. Thus, while outpatient costs have been increasing, some of this increase in utilization helped offset the use of more expensive inpatient services. However, there is not a direct one-for-one correlation between increased use of outpatient services and a decrease in inpatient utilization. Further, unit costs for outpatient care are not as well controlled as costs for inpatient care, where the use of diagnosis related groups (DRGs) or similar prospective payment methods limit charges per admission.[d]

"Previous efforts to curb rising costs of care have focused primarily on price because it is easier to address what something costs than to manage its utilization."

Technology

Greater availability and use of technology are also significant healthcare cost drivers.[17] Radiographic imaging has been one of the most significant technological advances in medical care. X-rays, introduced in 1895, were the first form of imaging. Newer forms of imaging emerging in the late 20th century included computed tomography (CT), magnetic resonance imaging (MRI), and positron emission tomography (PET). The current (2004) cost of a CT scan is more than $1,200, an MRI is generally just under $2,000, and a PET scan costs approximately $2,300.[9]

The availability of freestanding MRI and CT technology is associated with higher utilization and spending on these services.[17] However, the use of these imaging technologies for diagnosis has generally proven to be additive, rather than substitutive. A clinician may first order an x-ray or CT scan and then order another imaging technology, such as an MRI, to confirm or further investigate a suspected malady.[17] Therefore, while a diagnosis may be more accurate, the costs associated with determining that diagnosis are increasing.[18] The latest imaging technology, PET, uses radioactive substances to examine body functions, and it is increasingly used in screening for cancer and heart disease despite professional disagreement over some specific uses of this scanning technique. Between 1970 and 1985, North Carolina had only three PET scanners in the state, located at the largest hospitals. However, since 1985, 19 more PET scanners have been approved, and now all teaching hospitals have at least one PET scanner, and moderate size hospitals are applying for their use. This pattern of diffusion is typical for a new technology and will result in rising costs because of the wider availability of the scanners.

Prescription Drugs

The rising cost of prescription drugs is also a major contributor to increasing healthcare costs. In North Carolina, expenditures for prescription drugs increased 250% between 1990 and 2000 (see Table 1). More recent national data show that prescription drug expenditures increased 47% between 2000 and 2003.[19] Both public and private insurance programs have experienced double digit annual increases in prescription expenses.[20] This increase is due both to rising cost per prescription and an increased number of prescriptions filled.[13]

The rising costs of medications may be explained, at least in part, by the introduction of new medications into the market. The National Institute for Health Care Management (NIHCM) conducted a study of 1,035 new drug applications to the Food and Drug Administration between 1989 and 2000 and found that only 35% contained new active ingredients, while the remainder contained currently available active ingredients.[21] Furthermore, only 24% of the drugs offered clinical improvement. Of all the new drug applications, only 15% were both highly innovative and offered significant clinical improvement. In addition, of the $67.4 billion increase in spending on prescription drugs between 1995 and 2000, only 33% of the expenditures were spent on the pharmaceuticals that offered clinical improvements. This raises questions about the cost effectiveness of the increased spending on pharmaceuticals.

A significant factor in the high utilization of new prescription drugs is direct-to-consumer (DTC) advertising.[22] DTC advertising is a successful marketing tool. Drugs that are heavily advertised experience a significant increase in their use.[23] Yet, there are a

d Diagnosis related groups (DRGs) is a hospital payment system used by Medicare and many third-party insurers. It prospectively sets the hospital payment based on the patient's primary and secondary diagnosis, surgical procedures, age, sex, and the presence of complications.

number of concerns about such advertising techniques. Advertisements generally contain limited information about side effects and promote expensive brand name drugs over generics. Patients who see these ads may exert pressure on their physicians to prescribe drugs they have seen advertised, and this may lead to use of higher-cost drugs, rather than generic versions. In some cases, this could lead to inappropriate clinical use.

Malpractice

Rising malpractice premiums have been noted as a problem for some physicians in particular specialties and geographic areas. It may also negatively affect patients living in areas where physicians are no longer practicing presumably as a result of high premiums. Malpractice also contributes to rising healthcare costs because it leads to defensive medicine. Physicians may order unnecessary tests or procedures or avoid some high-risk patients, out of fear of potential malpractice liability.[24] While it is difficult to fully quantify the costs of defensive medicine, several recent studies suggest that malpractice costs and malpractice insurance premiums are not primary contributors to the rising costs of healthcare. One study reported that only 7% of the annual increase in healthcare costs can be attributed to litigation and risk management,[25] while another showed that malpractice costs account for a very small proportion of healthcare premium costs.[26]

Changes in Disease Prevalence and North Carolina Demographics

Changes in the prevalence of certain health problems underlie some of the increased use of health services and, consequently, relate to a portion of the increase in national healthcare spending. Healthcare spending is concentrated in a relatively small number of health problems. For example, almost one third of the change in healthcare spending between 1987 and 2000 was attributable to the treatment of five major health problems: heart disease, mental disorders, pulmonary disorders, cancer, and trauma.[29] Approximately half of the increase in health spending was attributable to 15 conditions.

For four conditions, cerebrovascular disease, mental disorders, pulmonary conditions, and diabetes, increased spending was due primarily to an increase in treated prevalence or number of cases.[e] In contrast, the increased cost per treated case was the primary factor underlying greater spending on trauma, pneumonia, infectious diseases, and heart disease. Overall population growth generally accounted for only 20-30% of the changes in healthcare spending for any specific condition.

Certain lifestyles choices and lifestyle-related illnesses contribute to many healthcare problems. Smoking, heavy drinking, and obesity[f] can lead to chronic health problems and, as a result, increased healthcare costs.[27] The growing epidemic of obesity is a major contributor to rising healthcare costs. Obese people have a higher risk of developing certain health problems, such as diabetes, hypertension, and heart disease. According to 2001 figures, 24% of the United States population is obese, an increase of ten percentage points since 1987.[28] The increased prevalence in obesity alone accounted for 12% of the real per capita spending growth between 1987 and 2001. Sturm analyzed self-reported health risk data from a national household survey and compared this to reported inpatient, outpatient, and prescription drug utilization. He found that obesity increased healthcare and medication costs by 36% and 77%, respectively, compared to someone with a normal weight.

Obesity has a much greater effect on the prevalence of chronic conditions than current or past smoking and problem drinking. However, current or past smoking also increased healthcare service costs 21% and medication costs 28-30%, depending on whether the individual was a current or past smoker. Compared to obesity, which increased absolute inpatient and ambulatory care costs by $395 per year, current or ever smoking was associated with a $230 increase, and problem drinking was associated with a $150 increase.[29]

North Carolinians, like Americans in general, are much more likely to be obese than they were even 15 years ago. In 1990, 12.9% of adult North Carolinians were clinically obese; in 2002, nearly one quarter (23.5%) were obese (see Figure 2). This trend in population health, although not a major contributor to the increase in healthcare costs, is generally appreciated by society. Although conventional wisdom holds that the increase in the proportion of the population that is overweight and obese is a major driver of cost trends, other factors outlined above, such as increasing use of technology, are more important.

A recent study found that many obese individuals do not realize they are obese.[29] Over 70% of normal weight individuals accurately identified themselves as such, but roughly 15% of obese people knew they were obese. All groups reported their height and weight equally well. This finding suggests that there is a need to increase awareness in the population of what a normal weight is.

It is a common misconception that our aging population is a major factor in explaining increases in healthcare costs. Adults over the age of 65 years do spend more per capita on healthcare than younger individuals. Therefore, as the overall population ages, healthcare spending also increases. However, the aging of the overall population is modest from one year to the next, so while it may have a long-term impact on costs, it does not significantly contribute to spending increases from year to year.

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e Depending on the condition, the increase in treated prevalence can be due to an increase in epidemiological prevalence of the condition (e.g., diabetes) or to the rate of treatment for a particular condition (e.g., mental health).

f In July of 2004, the United States Department of Health and Human Services announced its Medicare coverage policy would treat obesity as an illness. Obesity is defined as having a body mass index (BMI, calculated as weight in kilograms divided by height in meters squared) that is 30 or more.

Figure 2.
Weight Status of North Carolina Adults, 1990-2002

Source: Behavioral Risk Factor Surveillence System, Centers for Disease Control

Rising Health Insurance Premiums and Employer Response

One of the most closely watched measures of changing healthcare costs is the national Mercer/Foster Higgins survey of health benefit costs among public and private employers. This survey represents 600,000 employers with at least ten employees and more than 90 million full- and part-time employees.[g] Figure 3 illustrates changes in the total cost of healthcare benefits from 1988 to 2004. With the exception of a few years of modest increases during the mid-1990s, the cost of health insurance premiums has substantially increased each year since the late 1980s. Healthcare inflation increased at a greater pace than the general rate of inflation. Recently, those increases have moderated, and in 2004, benefit cost increases were 7.5%, down from increases of 10.1% and 14.7% in 2003 and 2002, respectively. While still significantly above inflation, it is the lowest annual increase in five years. However, there is a concern that this recent moderation in benefit cost increases underestimates the true cost escalation in the healthcare system. Rather than increasing premiums, many employers have shifted some of the healthcare costs to employees through increased out-of-pocket expenses, such as deductibles and copays. Figure 3 does not reflect the total increase in healthcare costs because it does not include out-of-pocket expenses.

A 2005 survey of employers by the Kaiser Family Foundation and Health Research and Education Trust indicates that many believe shifting costs to the employee is an effective way to control rising health insurance premiums (see Figure 4). This may be because employers feel they have run out of other viable options. But there could be unfortunate implications for their employees. Past studies suggest that higher out-of-pocket costs do deter utilization, and that individuals are equally likely to forgo necessary care as well as unnecessary care.[30] This is a

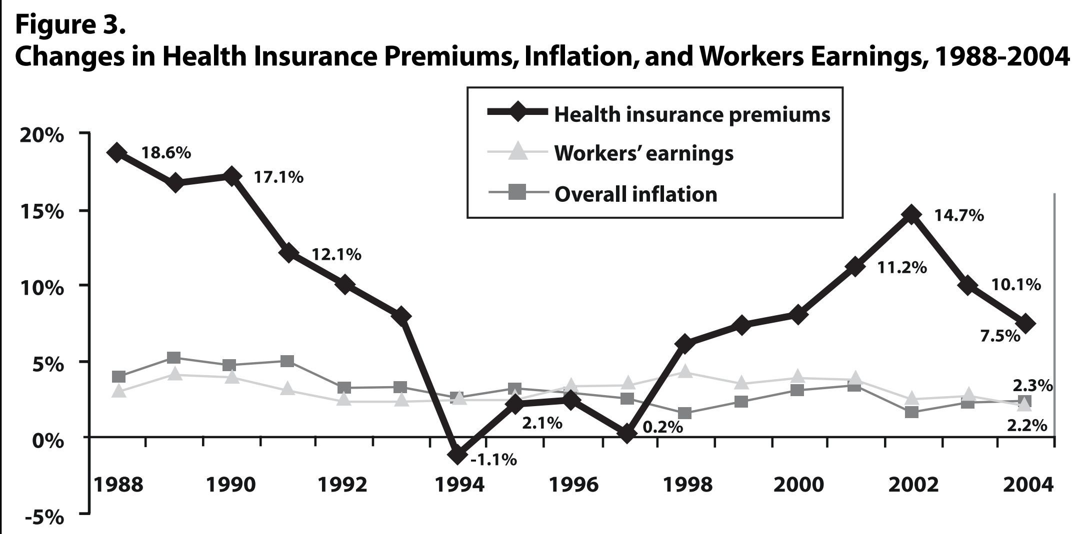
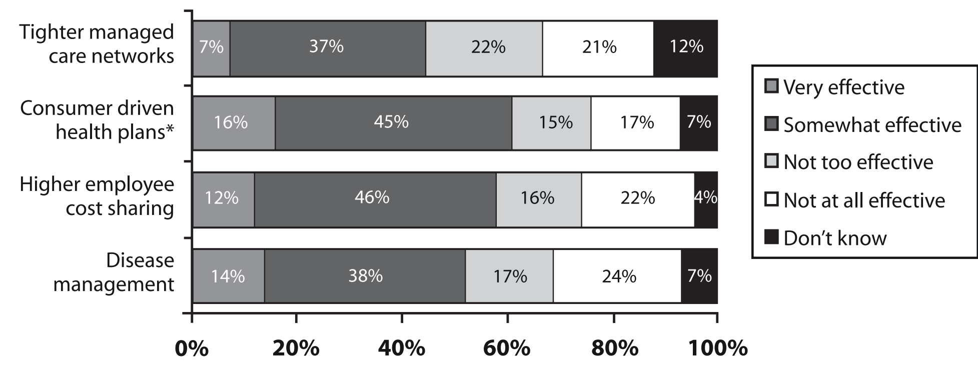


Figure 3.
Changes in Health Insurance Premiums, Inflation, and Workers Earnings, 1988-2004

Source: Mercer/Foster Higgins National Survey. (1988-2004). Wage data from: United States Department of Labor. Bureau of Labor Statistics. Average Hourly Earning s of Production Workers, Seasonally Adjusted. April data 2000-2004. General inflation data from: United States Department of Labor. Bureau of Labor Statistics. Consumer Price Index. All Urban Consumers. Not Seasonally Adjusted. April data 2000-2004.

g Another national survey conducted by the Kaiser Family Foundation (Kaiser) and Health Research and Education Trust (HRET) results in somewhat different estimates of premium increases. For example, in 2004, the Kaiser/HRET study showed an 11.2% increase from 2003. This study includes employers with three or more employees. The Mercer Foster Higgins study also includes public programs. These differences in study design help explain the different estimates of premium increases.

Figure 4.
Employers Opinions on the Effectiveness of Different Cost Containment Strategies



Source: Kaiser Family Foundation and Health Research and Education Trust. Employer Health Benefits 2005 Annual Survey. Exhibit 12.5.
*Consumer Driven Health Plans include high-deductible plans with a personal or health savings account.

particularly significant problem for low-income people, who are more likely to forgo necessary care and suffer adverse health outcomes as a result.

Employers are also trying to control rising healthcare costs by managing high-cost claims. A small percentage of the population accounts for the majority of spending on healthcare. In 1996, approximately 5% of the population accounted for 55% of total spending, and 30% of the population accounted for 90% of total healthcare spending. This trend has been consistent over time.

People with chronic conditions are included in the high-cost groups and many employers are trying to manage the high costs of chronic conditions through disease management (DM) programs. More than four fifths of covered workers (81%) are enrolled in plans that use case managers to coordinate the care of persons with high-cost conditions. More than half (56%) of all workers with employer-sponsored health insurance are in a plan with at least one disease management program. Of those covered by disease management programs, most workers are covered by programs that manage diabetes (99%), asthma (86%), hypertension (82%), and high cholesterol (66%).[31] Fifty-two percent of employers surveyed in 2005 indicated that disease management was a very or somewhat effective strategy to control rising healthcare costs,[32] although a review of studies examining the return on investment of disease management programs shows mixed results.[h,33] Given the frequent use of disease management programs in employer-sponsored insurance programs, there is a need for more evaluation of their effectiveness to understand where investments of this kind will pay off.

The Elusive Fix

It is not surprising that employers continue to struggle, with little success, in controlling the increases in their healthcare premiums. The healthcare system—the way it is structured, managed, and reimbursed—is complex. Solutions will be equally complex and can't be unilaterally imposed by any single segment of the healthcare system. Some critics say the problem is that patients and providers alike are too insulated from the costs of goods and services and suggest that plans that more closely align consumer/patient and insurer interests (such as Consumer Directed Health Plans[i]) would increase consumer awareness. Others call for more (or less) competition in the healthcare system to control costs. And others put the blame on lifestyles, and call on all of us to take better care of ourselves to reduce illness and healthcare use. While there may be some truth to all of these observations, our problems are more complex than these convey. It is true we have little competition in the provision of healthcare services, but competition rarely works in healthcare as it does in other sectors of the economy. Two high-cost open heart surgery programs in one community do not result in price competition. And arming patients with price information rarely is useful except for elective care, and then only when assuming there is a choice of providers. Patients usually go where their trusted physician directs them. Once a patient is sick and enters the healthcare system, tests and procedures are ordered *for* them, and there is little a patient can do to control the costs associated with their care. The American healthcare system tends to defer to the professional judgment of the physician as to what tests, procedures, and treatments are necessary to ensure the well-being of the patient. Healthier lifestyles are a laudable goal and should be a focus for employers and employees alike. Yet, the healthiest among us will most likely experience health problems at some point through no fault of their own. And once in the healthcare system, the costs are so great that most individuals need some form of assistance in the form of health insurance to afford their care.

Unfortunately, redesigning the American healthcare system

h A recent Cornell-Medstat study concluded the jury is still out on whether disease management programs deliver a return on investment. A review of 44 studies analyzing the economic impact of DM programs found mixed results for those targeting depression, diabetes, and asthma, which are the most common diseases targeted. However, those programs targeting congestive heart failure and multiple chronic conditions were more likely to be successful.

i The premise of Consumer Directed Health Plans (CDHP) is that there is costly, unnecessary use of healthcare services, and by transferring more responsibility for accessing and paying for care to the individual, cost-effective decisions will be made. CDHPs take multiple forms, and may include high-deductible plans, healthcare spending accounts, and tiered benefit plans.

to resolve these problems is an unrealistic goal. In the early 1990s, the American public soundly rejected the Clinton Plan to overhaul the system. And as the HMO backlash of the late 1990s taught us, Americans have been loathe to accept aggressive utilization review that would eliminate marginally beneficial healthcare services, so addressing the "demand" side of the equation is not likely to be fruitful. An alternative method of limiting the use of expensive healthcare services is to limit the supply of expensive technology. In North Carolina we do this to some extent with the Certificate of Need (CON) program. This is not without controversy and often leads to adversarial relationships as healthcare institutions and physicians disagree on whether a service in a particular community is warranted. As a society, we tend to question the use of expensive technology in the abstract. But most of us would have little difficulty advocating for the service when a loved one has even a small probability of benefiting from an expensive procedure. This disconnect between what is in *society's* and the *individual's* best interest is at the heart of the dilemma. Consequently, our attempts to fix the healthcare system will be limited to modest tampering around the edges of this monstrous system, and from modest reforms, we can only expect minimal improvements. **NCMedJ**

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COMMENTARY

Hospitals and the Uninsured:
One Hemorrhage at a Time, Please

William A. Pully, JD

Hospitals' promise to the uninsured: our open-to-everyone doors will never close on you. The bleeding reality: the closing doors of other providers and the narrowing reimbursement streams threaten hospital services, not only for the uninsured, but also for the insured.

North Carolina's safety net hospitals are straining under the weight of the rapidly rising numbers of uninsured and climbing demands and shrinking Medicare and Medicaid reimbursements. In addition to facing higher treatment costs, hospitals today are further stretched when other providers either cannot or elect not to continue services to specific populations. Hospitals are *their* safety net also.

One Hospital's Story

Centered in the state's southeastern coastal plain, Duplin county is agrarian, home to more than 50,000 residents. Agricultural jobs here make up over 16% of the workforce, a rate 23 times higher than the state average. Unemployment has fallen in recent years, but residents vividly recall 2000 and 2001 when the county's 23.1% and 24.8% respective joblessness rate ranked worst and next-to-worst in the state. The county also has one of the state's fastest growing immigrant populations. Hispanics, the majority of whom are uninsured, comprised 15.1% of Duplin county residents in 2000 and 18.6% in 2004, numbers that—like farm jobs—are several multiples higher than the state's 4.7% average.

Duplin General Hospital in Kenansville attempts to serve everyone. Eighty-nine of its 101 licensed beds are staffed and open. Twenty of those are for mental health patients, 20 are for those needing skilled nursing care, and nine are for intensive care patients. The hospital's emergency department welcomes 15,000 visitors annually. The surgery suites see 2,200 cases. The hospital discharges 4,200 patients annually and serves 48,000 outpatient visitors—almost one visit for every county resident each year. A more classic example of a "safety net hospital" does not exist.

Two categories of hospital services reveal distinctly different problems facing this hospital. Duplin General delivers between 600 and 700 babies each year. Obstetrics services seldom cover their costs. The percentage of births from the largely uninsured Hispanic population has mushroomed. In 2001, 33% of births at Duplin General were Hispanic. Births to the Hispanic population surpassed 40% in 2002. Over the past three years, more than half of the deliveries were by Latino mothers.

Meanwhile, Medicare and Medicaid patients are turning to the hospital's emergency department in greater numbers. Physician reimbursement rates that have either declined or failed to keep pace with rising costs are constricting access to primary care for these populations. These older, poorer, often sicker patients turn to hospital emergency departments when other healthcare options are closed. In the past year at Duplin General, Medicare patients accounted for 27% of emergency department visits; Medicaid patients 20%; and self-pay patients—the hospital field's euphemism for the uninsured—counted for 24%.

Similar percentages are setting off alarms all over the state. In the aggregate, North Carolina hospital emergency departments

"The combination of these losses has devastated the hospital's financial picture, drowning the $1.5 million excess of revenues over expenses in 2000 under a four-year pool of red ink."

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saw Medicare visits climb to 24%; Medicaid to 22%; and uninsured to 22%. All three groups' usage of emergency departments grew markedly—Medicare by 11%, Medicaid by 6%, and the uninsured by 10%. Combined, Medicare, Medicaid, and uninsured patients accounted for 2,169,006 of 3,432,486 emergency department visits in North Carolina hospitals last year.

For Duplin General, these numbers reflect not only growth among the county's uninsured population, but rising percentages of patients on Medicaid. The hospital's payer mix is over 40% Medicare, and Medicaid patients have reached or surpassed 20% each of the past five years. The hospital receives just over 85 cents on each dollar of its costs from these federal-state-local partnership payers. In one recent year, Medicaid reimbursement to the hospital was more than $750,000 below the incurred treatment cost for Medicaid patients. Statewide, hospital payments from Medicaid in 2005 fell almost $300 million below hospitals' costs. The estimated Medicare reimbursement shortfall ranges from slightly higher than the Medicaid shortfall to more than double that amount.

And, while government payments falter, Duplin General is seeing its totals for the conjoined twins of bad debt and charity care skyrocket. In 2000, their combination was more than $4 million. Bad debt and charity care totals surpassed $5 million the following year, eclipsed $6 million in 2003 and $7 million in 2004. This year the hospital expects bad debt and charity care to total $7.5 million. Statewide, hospitals provided more than $350 million in charity care in 2005 and estimated that bad debt costs were more than $530 million.

The combination of these losses has devastated the hospital's financial picture, drowning the $1.5 million excess of revenues over expenses in 2000 under a four-year pool of red ink. In 2003 and 2004, the hospital lost $2.2 million and $2.4 million, respectively. The depth of red ink decreased in 2005 before plunging to a loss of more than $600,000 through the first half of this fiscal year.

For Duplin General, the dollars are the easily countable portions of the effects of rising numbers of uninsured patients and inadequate government payments for Medicare and Medicaid patients. Harder to enumerate are the uninsured patients who do not have a family physician, although most will come to the hospital's emergency department for primary care. This inappropriate use overcrowds the facility and frustrates emergent patients, increasing dissatisfaction and fueling more liability cases. The low physician reimbursement rates, combined with climbing liability insurance coverage costs, push physicians away from private practice. The hospital finds itself forced to employ physicians, lose money, cut margins, and eliminate services. Some of the costs get shifted to other payers, making premiums spike and prompting employers to drop coverage for their workers. More people without insurance are the result. Not fixing one problem makes another accelerate exponentially.

The cascading financial woes that attend high Medicare, Medicaid, and uninsured populations push hospital trustees into difficult decisions regarding which services to continue and which to eliminate. Duplin General Chief Executive Officer Doug Yarbrough revealed his hospital has already dropped its physician clinic and its diabetes program. They are now squinting suspiciously at any other non-emergent service that does not cover expenses.

Widespread Misery

Duplin General is neither alone nor the worst case. Consider two measures of utilization for uninsured patients—the percentage of hospital charges in the self-pay category and the percentage of patient days in self-pay. Tracking those measures through general acute care patients and for all patients reveals how remarkably representative of North Carolina hospitals Duplin General is. Responses to the North Carolina Hospital Association's Advocacy Needs Data Initiative Survey indicate that 24 of 103 other hospitals in the state had greater percentages of charges in the self-pay category for general acute care and 32 others of 106 had greater percentages of charges for self-pay across all care. Duplin General is even more mainstream when viewed through the percentage of patient days prism. Forty-nine of 102 other hospitals had greater percentages of self-pay patient days for general acute care and 70 of 105 other hospitals had greater percentages of self-pay patient days for all categories of care.

The impact on a hospital's operating margin from high Medicare, Medicaid, and uninsured percentages is not subtle. In 2003, North Carolina hospitals with these high percentages averaged -0.6% from operations. The year 2004 was drastically worse, with a -3.3% average operating margin. Thanks to voluntary reporting of quality indicators opening access to a full market basket update on Medicare payments, 2005 average operating margins for hospitals with these high percentages were -0.5%. Hospitals with moderate percentages of Medicare, Medicaid, and uninsured patients averaged positive but narrow margins, while hospitals with the lowest percentages of these patients averaged operating margins of almost 5% or greater.

Such widespread misery—brought on by government underpayment for Medicare and Medicaid and government indifference toward the uninsured and those who serve them—jeopardizes care for all North Carolinians. **NCMedJ**

COMMENTARY

Latinos, Immigrants, and the Uninsured

Mark Holmes, PhD

I have presented data on the North Carolina uninsured a number of times over the past couple years to a variety of audiences. Typically each audience finds a particular point of interest—one audience may ask questions about the low-income uninsured, while another may be interested in the working uninsured—but in almost every situation, one of the first few questions is how either Latinos or immigrants (or both) affect the uninsured rate in our state. This question is not altogether unanticipated. The issue of immigration, legal and illegal, is particularly topical given the tremendous population growth over the past decade and the current political focus. An often cited statistic is that, on a percentage basis, North Carolina's Hispanic population was the fastest growing in the country from 1990 to 2000. Congress's consideration of immigration reform, and the subsequent public demonstrations, has focused national interest on the issue. Based on this widespread attention to immigrants in general, and how they contribute to the uninsured rate in particular, there is a cry for objective evidence. How much of the uninsurance problem *can* be attributed to Latinos and immigrants?

The simple answer, of course, is that there is no simple answer. Like most topics worth considering, there is no definitive answer and data can be used to support conflicting conclusions on the issue. However, when one examines the constellation of statistics on this issue, there is only one defendable conclusion: although Latinos and non-citizens in general are more than three times as likely to be uninsured than non-Latinos and citizens, other factors are more important causes of the problem.

"...two thirds of the difference in the uninsured rate among Latinos and non-Latinos can be explained by factors other than being Latino..."

Popular media coverage often blurs the definition between *Latinos, immigrants, non-citizens*, and *illegal* (or *unauthorized*) *immigrants*. Often, it appears, many people consider these groups identical. In North Carolina, however, 32% of non-citizens are not Latino, and 35% of Latinos were born in the United States.[1] Non-citizens include both those who are in this country legally (i.e., with work, student, or other visas), as well as those in the country without documentation. Although much of the consternation on this issue relates directly to undocumented (illegal) immigrants, most of the data sources on the uninsured contain no information on an immigrant's legal status.[a,2] Thus, this commentary focuses on ethnicity (Latino or non-Latino) and citizenship (citizen or non-citizen). In addition, I limit my focus specifically to insurance coverage. A broader assessment of the costs and benefits of North Carolina's immigrant population is well beyond the scope of this analysis.

Simple Comparisons of Uninsured Rates

It is useful to start with simple comparisons. As often mentioned elsewhere in this issue of the Journal,[3] most analyses of the uninsured consider only the non-elderly, since due to Medicare, less than 1% of the elderly are uninsured. Table 1 presents the uninsured rate by citizenship and Latino ethnicity. Slightly less than 18% of non-elderly North Carolinians were uninsured in 2004, although there are marked differences by

a One study estimates that 55.5% of North Carolina's Latino population is "authorized."[2]

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Table 1.
Uninsured Rate by Ethnicity and Citizenship, North Carolina 2003-2004

	Not Latino	Latino	Total
Non-citizen	21.9%	73.0%	57.7%
Citizen	15.1%	25.2%	15.4%
Total	15.2%	53.6%	18.0%

Source: Current Population Survey Annual Social and Economic Supplement, US Census Bureau and Bureau of Labor Statistics

both citizenship and ethnicity. While 15% of North Carolina citizens are uninsured, more than half of non-citizens are uninsured. Likewise, 15% of non-Latinos are uninsured compared with 54% of Latinos.

The data can also be considered from another perspective. Latinos represent approximately 7% of the North Carolina population, while non-citizens represent 6%. Of the 1.3 million uninsured, however, Latinos and non-citizens are overrepresented: 22% of the uninsured are Latino, and 20% of the uninsured are non-citizens. Of North Carolina's 1.3 million uninsured, approximately 170,000—just over one in eight—were born in Mexico.

Trends

Another way to consider the role of Latinos and non-citizens would be to look at changes over time.[b] In 2000, roughly 13.4% of non-Latinos were uninsured; that grew to 15.0% in 2004, an increase of 1.6 percentage points. That is, examining only non-Latinos, the uninsured rate grew from 2000 to 2004. The uninsured rate for Latinos, however, grew substantially, from 37.8% to 51.8%, an increase of 14 percentage points. Likewise, the number of uninsured increased by more than 200,000 for non-Latinos and roughly 125,000 for Latinos. Given the total increase of 334,290 in the uninsured, the growth in the number of non-Latino uninsured represented 63% of the total increase in the North Carolina uninsured from 2000 to 2004.

Another way to analyze the changes is to try to discern whether the increase in the number and percent of uninsured Latinos is due to changes in the state's demographics (the percent of population that is Latino), or changes in the within-demographic uninsured rate (the percent of citizen Latinos who lack health insurance). Performing this analysis shows that one quarter to one third of the change in the percentage of North Carolinians who are uninsured between 2000-2004 were driven by changes in the population. The remaining two thirds to three quarters are due to uninsured increases within each group. Note that the percent of citizen non-Latinos—93% of the North Carolina population in 2000—who were uninsured increased 1.4 percentage points from 2000 to 2004. Thus, the increase in the uninsured rate in citizen non-Latinos alone was responsible for roughly 1.3 percentage points statewide—almost half the increase in the uninsured rate from 2000 to 2004.

Nationally, states with proportionately more Latino and/or non-citizens have higher uninsured rates. The question, of course, is whether this relationship is a direct result of high Latino/non-citizen populations, or whether Latino/non-citizen individuals have other risk factors making them likely to be uninsured.

Behind the Curtain—Latinos and Immigrants Have Increased Risk Factors for Being Uninsured

Of course, Latinos and non-citizens have other factors beyond their ethnicity/citizenship status that make them likely to be uninsured. For example, both Latinos and non-citizens are more than twice as likely to have incomes below poverty guidelines, and full-time workers are nearly twice as likely to

Table 2.
Single Year Estimates of the Uninsured Population of North Carolina, 2000-2004

	Percent Uninsured			Number of Uninsured		
Year	Non-Latino	Latino	Total	Non-Latino	Latino	Total
2000	13.4%	37.8%	14.8%	839,752	139,940	979,692
2001	14.4%	43.5%	16.3%	960,877	202,401	1,163,278
2002	16.8%	52.2%	19.0%	1,128,732	233,312	1,362,044
2003	15.8%	58.2%	19.4%	1,051,870	361,796	1,413,665
2004	15.0%	51.8%	17.5%	1,049,697	264,285	1,313,982
Change 2000-2004	1.6%	14.0%	2.7%	209,945	124,345	334,290
Percent of non-elderly North Carolina uninsured population				63%	37%	100%

Source: Current Population Survey Annual Social and Economic Supplement, US Census Bureau and Bureau of Labor Statistics

b The data in Table 2 do not use the two-year averaging used elsewhere in the commentary, so the numbers are slightly different.

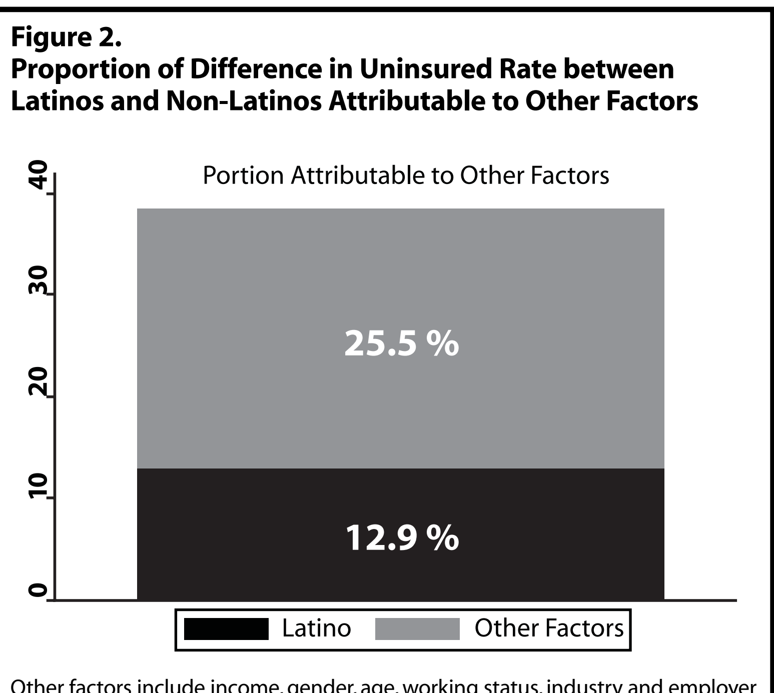
work for a small employer (less than 25 employees). Both low-income and small-employer workers are more likely to be uninsured. Other risk factors for being uninsured are higher among Latino and non-citizen populations. Both groups are much more likely to be male, young adults (25-34), and work in low-coverage industries, such as agriculture, construction, and hospitality.[c,4] In addition, low-income Latinos, especially recent immigrants or people without documentation, are also less likely to qualify for publicly-subsidized insurance, such as Medicaid or North Carolina Health Choice.[d]

After adjusting for the differences in these underlying characteristics, the difference in the uninsured rate attributable to being Latino decreases by 67%, from 38 percentage points to 12 percentage points. In other words, two thirds of the difference in the uninsured rate among Latinos and non-Latinos can be explained by factors other than being Latino *per se*. Similar results hold for citizenship. Note that differences in the rate of being uninsured remain even after adjusting for demographic and socioeconomic differences between the Latino and non-Latino populations.

The Final Answer: A Considerable Contributing Factor, but Not the Largest Driver of the Increase

The evidence, taken in totality, presents a mixed picture. Some statistics in this commentary may seem to prove that Latinos and/or non-citizens are the primary driver of the uninsured rate in North Carolina. Viewed in totality, though, the evidence suggests that other factors, such as socioeconomic status, place of employment, and inability to access publicly-subsidized insurance, may be the factors driving the lack of coverage. The evidence here is consistent with other research, taken from a national perspective, which found that the primary driver of the increase in the uninsured is the increase in health insurance premiums and not changes in demographic or socioeconomic characteristics of the population. One analysis of changes in the uninsured rates of metropolitan areas found that the primary determinant was the increase in the cost of health insurance.[5] Changes in the percent of the metropolitan area residents that were foreign born were generally unrelated to changes in coverage. Another study found that changes in the socioeconomics and demographics of working adults from 1987 to 2002 predict a half a percentage point decrease in the nationwide proportion uninsured. The authors found that the increase in the percent of population that is Latino explained half a percentage point increase in the uninsured rate.[6] A study of immigrants in Los Angeles county found that socioeconomics explained most of the difference in coverage rates between non-native born and native born, but undocumented immigrants remained 16 percentage points more likely to be uninsured after accounting for the differences in employment and other characteristics.[7] The authors claim that extrapolation of their data to national trends suggests that undocumented workers are responsible for about one third of the increase in the number of uninsured adults nationally from 1980-2000. Another study found that nationally white non-Hispanics experienced the greatest increase in the percent of people who were uninsured (1.9 percentage points).[8] The percentage of Hispanics that were uninsured declined 0.3 percentage points from 2000 to 2004. Note the difference in finding from the Gilmer and Kronick article, which underscores the sensitivity of the relationship between the growth in the Latino population and the increase in the rate of uninsurance.[9] Of course, these are national data, which may or may not translate to the specific experience of North Carolina.

Figure 2.
Proportion of Difference in Uninsured Rate between Latinos and Non-Latinos Attributable to Other Factors



Other factors include income, gender, age, working status, industry and employer size. Unadjusted difference is 38.4 percentage points.

c Other differences exist, including some that cannot be evaluated specific to North Carolina. One study, for example, found that non-citizens were more likely to work at firms that did not offer health insurance.[4]

d Federal Medicaid and State Child Health Insurance Laws limit coverage to individuals who meet certain eligibility requirements. To qualify, a person must be either a citizen or an immigrant with certain immigration status who has been in the country for at least five years. Additionally, individuals must meet other categorical and eligibility requirements, such as income or resources. Thus, many low-income Latinos are ineligible to receive regular Medicaid or North Carolina Health Choice benefits, even though they might otherwise meet the eligibility requirements.

The Latino and non-citizen populations of North Carolina continue to increase and are likely to continue growing as they have over the past decade. As we monitor more closely the increasing ranks of the uninsured, the Latino and non-citizen populations will bear closer inspection. Potential policy solutions should be constructed that are cognizant of the large numbers of uninsured who are ineligible for public programs due to their citizenship status. However, the majority of the North Carolina uninsured are non-Latino *and* citizens, so equating "the uninsured problem" with "the immigrant problem" is inaccurate. Addressing the increasing numbers of uninsured is within the realm of our state-level policy capability, and it does not depend on marginalizing our newest North Carolina residents. **NCMedJ**

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Health Insurance Coverage:
A Luxury for Most North Carolina Latinos

Javier, his wife and three children moved to North Carolina in June 2000, after Javier lost his job in San Luis Potosí in central Mexico. When first moving to Siler City, Javier worked as a day laborer, doing odd jobs for anyone willing to hire him for a few hours a day. As a day laborer, Javier met the owner of a small landscaping company, and eventually, started working for him full-time. The landscaping business was small, with only four employees, and did not offer health insurance coverage to its workers. Urgent care clinics expected to be paid in cash the day of the visit, and the family doctor in the area charged more per visit than Javier made per day. Javier and his family had no choice but to rely on the emergency room for care.

After six months of working in the landscaping world, Javier found a job at a local poultry plant working third shift. He looked forward to working at a job indoors, where the weather would not impact his ability to earn a living. At this new job, Javier was offered health insurance for his family: $110 a week, $440 a month. However, Javier and his family rely on every penny of his paycheck to buy food and clothing; therefore, not making the purchase of health insurance coverage an option.

Javier's ten year–old son, Gabriel, has asthma, which gets worse in the winter months. In the past few years, the family has learned to manage his asthma. However, a couple of times a year, Gabriel's mother wakes up in the middle of the night to hear Gabriel struggling for air. She offers him chamomile tea and gives him a bath, hoping that the steam will help him breath better. Her remedies help—most of the time. But some times, he continues coughing and struggling for air, even after she has exhausted all of her home remedies. Not knowing what else to do, she takes him to the emergency room, where he receives the care he needs; and she is lectured about the importance of Gabriel using his inhaler on a daily basis. She is too embarrassed to explain to the nurse that without health insurance coverage, unless her husband is given the chance at the poultry plant to work overtime hours every week, his family cannot afford the cost of Gabriel's asthma medication, which is more than $100 a month.

Currently, Javier owes the emergency room over $6,000 in medical bills. For Javier and his family, depending on the emergency room is their only option for medical care. They have learned that even if emergency room visits are expensive, they can make small monthly payments and do not need to have cash on hand. Not being a United States Citizen or a Legal Permanent Resident, Javier's family does not qualify for Medicaid or North Carolina Health Choice, the publicly funded safety net insurance programs for most low-income North Carolina residents. Their family has no safety net; their only hope is that Gabriel will outgrow his asthma. For Javier and his family, like for most low-income families in our state, purchasing private health insurance is not an option, but a luxury they cannot afford. This case, unfortunately, is not an exception, but one that reflects the reality of many Latinos living throughout our state.

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COMMENTARY

Caring for the Uninsured:
A Physician's View from the Safety Net

C. Annette DuBard, MD, MPH

Making do without health insurance is an experience familiar to an increasing number of Americans. By now, 13% of non-elderly adults have had at least one gap in coverage during any two-year period. Included among them are a disproportionate number of racial and ethnic minorities and an alarming proportion of the poor. Lack of health insurance typically does not reflect a lack of need for healthcare. On the contrary, the uninsured consistently have worse clinical outcomes and suffer greater risk of premature death than the uninsured.[1] The uninsured share something else in common—a front-row view of the worst our healthcare system has to offer: maldistribution of primary and preventive care availability, fragmentation of services and lack of communication between providers, and the exorbitant price inflation that results from layers of overhead costs and complex payer arrangements.

Inside the Safety Net

I work in the so-called safety net, as a family physician in a federally-supported community health center, where virtually all patients live below 200% of the federal poverty level, and 40% are uninsured. Community health centers pride themselves on providing affordable, comprehensive, patient-centered primary care regardless of a patient's ability to pay. By multiple measures, such clinics provide a quality of care that equals or exceeds that of other healthcare providers, alleviates the health disparities that are plaguing our nation, and reduces overall healthcare costs by decreasing preventable hospitalizations and emergency department use.[2-8] We are only one small piece of the safety net puzzle, which includes health departments and free clinics, hospitals and outpatient teaching clinics, and the countless private practice physicians who absorb much of the cost of caring for the uninsured.

It is a joy to provide a true medical home for patients who are so accustomed to being shuffled around and receiving band-aid solutions for immediate, acute healthcare needs, with no plan for follow-up care beyond "anywhere but here." Uninsured patients who find their way into a stable source of ongoing, affordable, comprehensive primary care must learn a whole new way of interacting with the healthcare system. It becomes possible for them to think beyond immediate concerns, toward long-term approaches to maintaining good health and responsibly managing chronic disease. My vantage point debunks the negative mythology that surrounds the uninsured. I don't feel like anyone is looking for an opportunity to sue me, or wanting "something for nothing." I don't feel a lack of "gratitude." Typically, the more I understand of my patients' lives, the more I respect what they're up against. Nationally, more than 8 in 10 uninsured come from working families. My billing office, which discounts charges based on the patient's income, reports that 90% of our patients pay 100% of what is asked of them.

"More than 40% of the uninsured have no regular source of care, and 20% consider the emergency room to be their regular source of care. Almost half have had to postpone seeking care because of cost within the past year."

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The Skill Set of Safety Net Providers

The core competencies of my job—what I know of the social, behavioral, and environmental determinants of health, the workings of social services, and the politics of healthcare—I've learned on the job, patient by patient. Taking care of the indigent uninsured requires a skill set that is not measured by any degree, board certification, or compensation system. It requires communication in a language that the patient can understand—for almost half of my patients, that means Spanish. For so many others, it's English at a fifth grade level. It requires a willingness to accommodate to the demands of my patients' lives—their complicated work schedules, frequent changes of address and intermittent phone service, the unpredictable availability of transportation or childcare from a friend or family member—which means working in one more patient at the end of today who didn't show up yesterday and taking on far more than just the "chief complaint" at any visit. It requires agility in pharmaco-economics at the micro level: emptying the grocery sack full of assorted pill bottles and samples or scrutinizing the stack of unfilled prescriptions from the last hospital discharge and starting over based on the amount of cash in the patient's pocket. Which can be substituted with a cheaper alternative? Could we get this one from a patient assistance program? What must be filled today; what can wait until the next paycheck; and what can we do without?

We learn, in the primary care safety net, an alternative way of doing medicine: what you can with what you've got. Expertise in our field requires knowledge of at least two approaches to any diagnostic or therapeutic problem. If you come to me with worsening asthma, or severe headaches, or abnormal liver tests, or infertility, I will flip straight to the section of your chart that tells me whether you have insurance. I will provide you the best care I can, but it will be tailored to your situation—which medications you can afford to try, which tests you can afford to undergo, how likely a specialist is to see you in consultation. I shoulder the knowledge that if my patient has a need that I can't take care of, that need will likely go unmet. So I've learned how to apply dental varnish for children who can't see a dentist. I do office procedures for which insured patients would be referred elsewhere. I work into my rushed visits tidbits of dietary guidance for diabetics who have no access to a dietician and brief counseling for patients suffering mental illness who have no access to a mental health professional. It is not enough.

When the Safety Net Falls Short

When patients' needs extend beyond primary care, my role is to help them navigate the healthcare system outside my doors, which is a challenge for anyone, but a particularly daunting task for those with no buying power (even if, like my patients, they live within 45 minutes of four hospitals, in a region of the state with one of the highest concentrations of specialist physicians). The tertiary medical center will say, "that sounds like something that can be handled at the local hospital," and the local hospital will say, "that sounds more appropriate for the tertiary medical center." For less urgent requests for consultation, any number of barriers may fly up. Patients may be asked to pay in full up front, to arrange an appointment with a financial counselor before a medical appointment can be made, to bring their own interpreter if Spanish-speaking, to send in written information or prior medical records for review and await a phone call if the referral is deemed appropriate. Important and substantial exceptions to this can be identified in every community, but institutional barriers to getting patients to the care they need grow in direct correlation with growth in the number of uninsured and under-insured. Too often, that means patients leave my office with the disgraceful advice: "you'll just have to go to the emergency room the next time it happens (the chest pain, the gallbladder attack, the seizure, the severe headache)."

It's Time for Real Solutions

All this is to say that strengthening the primary care safety net is a good and critical thing, but it will never be a substitute for universal health coverage. Despite federal initiatives that have emphasized expansion of safety net capacity in recent years, healthcare providers serving the uninsured are feeling increasingly strained. The 1.3% increase in total federal spending for care for the uninsured from 2001-2004 pales in comparison to the 11.2% increase in the number of uninsured over this time period.[9] More than 40% of the uninsured have no regular source of care, and 20% consider the emergency room to be their regular source of care. Almost half have had to postpone seeking care because of cost within the past year.[10]

Is it not shameful that in this, the richest nation on earth, 45.5 million people cannot count on access to basic healthcare services? Are we to be proud of our achievements in building the "best medical care in the world" while rationing that care in the most vicious of ways: all for some and none for so many? When I go to work tomorrow, I can expect to see someone whose colon cancer wasn't diagnosed until too late because screening was not available to her. I will see someone who has been disabled by a stroke because he never received adequate care for his high blood pressure and diabetes. I will see someone who keeps missing work or school because of asthma attacks, but cannot afford the medicine that would prevent them. What my patients need is not a safety net, but a healthcare system that makes sense. **NCMedJ**

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COMMENTARY

A Perspective on the Dentally Uninsured

M. Alec Parker, DMD

For many fortunate North Carolinians, "access to care" is something that is taken for granted. Through employer-funded benefit plans, many people have dental insurance benefits that help defray some of the costs of dental care for themselves and their families. These dental plans have been especially popular within the benefit packages that are offered by larger companies and corporations as a way to recruit and retain employees. But this trend is changing. As employers seek ways to cut costs, some employees are experiencing cutbacks in their dental insurance coverage. Others are seeing those benefits disappear altogether. Although the loss of dental benefits is not nearly as devastating as the loss of medical coverage, it does create a financial hardship for those who do not have the discretionary income to spend on oral health needs.

Lack of Dental Insurance Affects Vulnerable Populations

In 2000, the United States Department of Health and Human Services published *Oral Health in America: A Report of the Surgeon General*,[1] which found that 108 million children and adults in the United States had no dental insurance—twice the number of Americans who had no medical insurance. And it seems that those who suffer the most as a result of the lack of insurance are the most vulnerable—the very young and the very old. Like any other problem, the first step toward finding a solution is awareness. Unfortunately, one of the most frustrating problems is that those individuals and groups who tend to be at the highest risk for dental diseases seem to be the most overlooked or most unaware. For example, some parents do not recognize the importance of caring for their children's primary teeth because most of those teeth will be gone by the time they are in middle school. They don't realize that they are important not only in the development of proper speech and a healthy self-image, but that they allow the permanent teeth to erupt into proper position. Others do not realize the negative impact that diets high in sugar can have on oral health. Of particular concern is the amount of soft drinks consumed by school-age children. It is alarming to note that 51 million school hours are lost each year due to dental-related health problems.

Elderly people face a different scenario. Many still harbor the belief that they should expect to lose their teeth as they get older. This belief tends to cause older adults to decrease the number of dental visits for routine preventive care at a time when their dentition is beginning to become more vulnerable. Tooth loss can lead to a multitude of dietary and lifestyle compensations. Many older adults find themselves in nursing homes or other assisted living facilities that can limit their access to dental care within their communities. Although some of these facilities have contracts with dentists to provide dental care to their residents, most utilize the offices of private practitioners to deliver care for those who are healthy enough to be transported. Without access to regular checkups and preventive visits, older adults face an increased likelihood of chronic oral pain resulting from periodontal diseases and tooth loss due to extraction for cases of untreated decay. If left untreated, these dental problems can limit normal daily activities, affect their nutritional intake, alter their level of independence, and complicate other existing overall health issues.

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Dental Insurance

In order to understand the impact of being dentally uninsured, it is important to understand that there are some basic differences between dental insurance and medical insurance. One of those differences is that dental insurance plans have traditionally offered financial incentives for patients to seek regular preventive dental care, such as cleanings, examinations, and radiographs. These incentives are built into the reimbursement rates whereby patients receive up to 100% coverage for these diagnostic and preventive services. This encourages patients to visit their dentist regularly so that potential problems can be diagnosed and treated before they become both more complex and more costly. This arrangement works well for both the patient and the insurance company since it saves both parties time and money.

There are three types of dental insurance plans available in the marketplace—traditional insurance, managed care plans, and direct reimbursement. It is important to look at the most common features of traditional dental insurance plans and then see how those features compare with the other types of insurance. First, the traditional plan allows patients freedom of choice when it comes to selecting their dentist. There is no financial incentive for them to choose one dentist over another. Second, most traditional dental insurance plans have an annual maximum benefit. This is usually $1,000 to $1,500 per year for each individual covered by the plan. To further help promote preventive care and to control costs, most plans pay up to 100% of the cost of diagnostic and preventive services. For more routine restorative procedures, such as fillings, most plans pay about 70 to 80%. Reimbursement levels usually drop to about 50% for more complex restorative needs, such as crowns and other prosthetic appliances.

Managed care plans work differently. Insurance companies market these plans in an effort to help control their administrative fees and serve as an alternative to employers who might be looking to lower their premium costs while continuing to provide dental benefits to their employees. The most popular managed care plans being marketed in North Carolina are called "Preferred Provider Plans." Insurance companies seek to assemble a network of providers ("Preferred Providers") who agree to serve the dental needs of those patients whose employers have chosen to purchase the plan for their employees or offer the plan as an individual group purchase option. Managed care plans offer similar incentives to patients by encouraging regular preventive care. They also have annual maximum benefit levels as well as a tiered payment system based on the agreed upon fee schedules accepted by the participating dentist. The cost savings are available to the insurance company by recruiting dentists who agree to accept a fee schedule that is usually discounted 10-to-30% below the prevailing fees within the geographic area. In return for agreeing to discount his/her fees to those within this plan, the insurance company places the dentist's name on a list of their "Preferred Providers." As an incentive for patients to seek care in the office of a "Preferred Provider," they are often offered an additional discount relative to their out-of-pocket co-payments or deductible amounts.

The third, lesser known, type of plan is Direct Reimbursement (DR). This option was developed by the American Dental Association as a self-funded, tax deductible strategy to help employers control escalating premium costs while providing their employees with excellent dental benefits. Unlike traditional plans, there are no monthly premiums for employers to pay since there are no administrative costs built into DR. Employers only pay when an employee utilizes the plan. (Administrative fees charged by insurance carriers can account for up to 25% of the total annual costs of the plan.) Organizations that choose DR have the opportunity to select a dollar amount plan designed specifically for their employees, while setting an annual maximum limit for the year. This allows them to know their total investment for the plan without the worry of increasing premium costs year after year. It is interesting to note that since 1985, DR has experienced only a 2% turnover rate compared to the 10% or higher termination rate within other types of plans. This retention rate can be attributed to the cost-effective, non-networked dental benefits that are appreciated by both employers and their employees. Direct Reimbursement in North Carolina currently has 200+ participating groups covering more than 80,000 people, and it continues to gain market share in this very competitive environment.

Dentists Helping Low-Income Patients without Dental Insurance

For those individuals who are not fortunate enough to have dental insurance benefits and cannot afford to pay the total costs of obtaining dental care in a traditional fee-for-service environment, there are several opportunities for them to obtain dental care. Medicaid benefits are available to many low-income residents of North Carolina. The major barrier with having these benefits is finding a dentist who can afford to provide care given the low Medicaid reimbursement rates. Many counties have dental clinics within their health departments that charge fees on a sliding scale based on household income in an effort to make care more affordable. There are numerous "free clinics" sponsored by local dental societies where practitioners volunteer their time in the evenings or on days off to provide care at no cost. Often dental supply companies donate supplies to help support these charitable efforts. Finally, there are many dentists who provide care at reduced fees for those individuals and families in their practices and in their communities who cannot afford to pay their usual fees.

In addition to these ongoing efforts, there are also other events sponsored by local dental societies and charitable organizations that offer free care by targeting specific populations at different geographic locations throughout the state. For example, the American Dental Association and the North Carolina Dental Society co-sponsor "Give Kids A Smile" on the first Friday in February each year. On that day, each of the 100 counties in North Carolina has an event that provides some type of free dental care to children. Since the program began in 2001, more than 34,000 North Carolina children have received in excess of $3 million in dental care from more than

4,500 dental volunteers. The Duke Endowment and the Kate B. Reynolds Charitable Trust provide financial support for Mission of Mercy Projects scheduled in different locations across our state throughout the year. These are usually two-day events where volunteer dentists set up portable dental equipment in large buildings to provide free care to local low-income residents. It is not unusual for these events to provide free care to several hundred people in a single weekend.

Like any other problem, the first step toward a solution is awareness. The challenge is to effectively educate all of our citizens about the benefits of good oral healthcare regardless of their age or income level. This is especially true for those individuals who are in positions to affect public opinion and public policy. These state and community leaders must be made aware of the overall health risks that are exacerbated by poor oral health habits. If policy makers were aware of the growing body of evidence that suggests a very strong link between oral and systemic health, most would take a more proactive position on assuring that there were mechanisms in place to improve the oral health of our citizens. Improvements in Medicaid reimbursement rates for both children and adults would go a long way in helping to address care to the dental uninsured.

Improving Oral Health Depends on Our Commitment to Dental Care

The real answer to the problem of the low-income dentally uninsured population lies with our society and its degree of commitment to dental care. It is interesting to note that our government provides food stamps to help low-income populations purchase food. Those who are eligible for food stamps can use them at any grocery store to purchase food at 100% of the face value indicated on the food stamp coupons. Also, Medicaid reimbursements for covered *medical* procedures are reimbursed to our medical colleagues at amounts that are equal to 90 to 100% of the Medicare allowable rates. And although progress is being made to increase dental Medicaid reimbursement rates, many procedures continue to be reimbursed at levels less than 50% of their usual costs. At those rates, dentists are losing money each and every time they perform dental procedures for Medicaid recipients. The harsh reality is that society has determined that providing food and medical care for low-income individuals is more important than providing them with dental care. And, until the citizens of North Carolina, and specifically those who serve in our legislature, begin to think differently, we will continue to struggle to find innovative ways to address the dental, emotional, and other health-related problems that low-income individuals experience as a result of those current priorities. **NCMedJ**

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COMMENTARY

Small Employers and the Provision of Small Group Health Insurance Coverage

Connie Majure-Rhett, CCE, and Kristen L. Dubay, MPP

Overview

Employers are the main source of health insurance for North Carolinians. In 2004, more than 60% of non-elderly North Carolinians accessed health insurance coverage through an employer-sponsored health insurance program.[1] However, small businesses are much less likely to offer health insurance coverage than larger business. In 2002 and 2003, only 29% of North Carolina firms with fewer than ten employees offered health insurance coverage, compared to 68% of firms with 10-24 employees, 79% of firms with 25-99 employees, and 90% of firms with 100 or more employees.[2]

One reason that fewer small firms offer health insurance coverage may be due to higher health insurance premiums, on average, for smaller firms. In North Carolina, 2002-2003 the average annual health insurance premium for workers in small firms with fewer than 50 employees was $3,597, compared to $3,206 for firms with more than 50 employees.[3] Small employers, those with 50 or fewer employees, are subject to health insurance rates set by state "small group" rating laws. These laws were modified in the 1990s to reduce the variation in premiums charged to small employers with similar employment characteristics. Small group rating laws are used to spread the health risks of small employer groups across a larger pool of workers. However, despite these laws, small-firm premiums continue to vary widely, and health insurance premiums are still higher on average for small firms than for larger firms.

"Many workers remain in jobs that might not be their preferred position because of good health insurance."

Reasons for (Not) Offering Health Insurance

Nonetheless, some small employers still feel that it is important to offer health insurance to their employees. Some employers choose to offer health insurance in order to attract the most qualified workers. This may gain importance as our population ages—a serious concern for small employers. Beginning in 2006, for every two "baby boomers" who retire, only one new worker will join the workforce.[4] The decreasing size of the workforce is making the hiring process more competitive for small employers. As a result, the ability to offer a comprehensive benefit package, particularly one with healthcare coverage, is integral to attracting the most talented and qualified employees.

Offering health insurance is also connected to worker retention. Many workers remain in jobs that might not be their preferred position because of good health insurance. For example, married men who receive health insurance from their employer are approximately one-third less likely to leave their jobs than married men not receiving health insurance from their employers.[5,6]

A few small employers choose to offer health insurance coverage to employees because the employer would be unable to access affordable insurance for themselves or their own family members in the non-group market due to pre-existing health conditions. Other employers offer health insurance coverage in lieu of providing higher wages. Research indicates that some employees would support that decision. A survey conducted

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for *The Wall Street Journal Online's* Health Industry Edition found that more than 60% of adults with employer-sponsored health insurance would prefer no pay increase while maintaining or increasing health insurance coverage rather than receiving a pay increase and a decrease in health insurance coverage.[7]

Nonetheless, employers' desires to provide health insurance coverage often contrast with their financial abilities to afford coverage. There are many reasons that employers choose not to offer health insurance coverage, but the main reason is cost.[8] In addition to the higher average health insurance premium costs for small businesses compared to large ones, small business owners also are often unable to hire a benefits manager and must spend considerable time completing the administrative tasks associated with offering health insurance.[9] Facing annual premium increases, many small businesses shop around for lower prices, compounding the administrative burden imposed on the owners or managers. Finally, in a small business group, a serious health event experienced by a covered worker can also significantly increase the premiums for the group as a whole in the following year, thus making it difficult to continue to offer insurance and maintain participation rates.

Another barrier that small businesses face is minimum participation requirements. Many health insurers require businesses to insure at least 50-75% of eligible employees in order to offer the coverage. Presumably, insurers have this requirement in order to prevent adverse selection into the plan. However, this requirement can be very challenging for small businesses, particularly for those with a high proportion of lower-income workers who cannot afford their share of the insurance premium. There are many small employers around the state who would like to offer coverage, but who cannot because they cannot meet the minimum plan participation requirements.

The Role of Small Businesses in the North Carolina Economy

Small businesses play an integral role in the state's economy. Therefore, everyone stands to benefit from ameliorating the challenges facing small businesses and their employees in their quest to obtain affordable health insurance coverage. In 2003, approximately 74% of private-sector establishments in North Carolina were small businesses with less than 50 employees, and 55% were very small businesses with less than ten employees.[10] Of all employees working in private-sector establishments in North Carolina in 2004, more than 26% of workers were employed by an employer with less than 50 employees, and 11% worked for an employer with fewer than ten employees.[11] Additionally, annual payrolls for North Carolina small firms with less than ten employees accounted for more than $9.5 billion in 2003, and small firms with less than 20 employees accounted for more than $15.8 billion in annual payroll.[12]

Therefore, when small businesses are unable to offer health insurance coverage to their employees, the economic impact is felt across the state. People without health insurance coverage use fewer healthcare services and often end up with health conditions that could have been prevented. As a result, the lack of insurance impacts worker productivity. Workers without insurance have 10% more sick days than those with healthcare coverage.[13] Additionally, some estimates indicate that providing health insurance coverage to those without it increases annual productivity and earnings by 10-30% annually.[14] Nationally, the Institute of Medicine of the National Academies estimated that between $65 billion and $130 billion is lost annually due to the poorer health and premature deaths of the uninsured.[15]

Policy Options for Small Business Health Insurance Coverage

Expanding health insurance coverage across North Carolina for all population groups would be beneficial, but the need for some immediate solutions is particularly acute for small businesses. There are a number of potential policy options at both the state and national levels for expanding health insurance coverage to small businesses. Some of them were highlighted in the North Carolina Institute of Medicine's *Covering the Uninsured Task Force report,*[16] and others have been introduced into the North Carolina General Assembly or in the United States Congress.

The North Carolina Institute of Medicine (NC IOM) Task Force recommendations that would particularly benefit small businesses include: development of a Healthy North Carolina program, implementation of a high-risk pool, expansion of the Medicaid program for low-income parents, and reviewing the impact of the state's small group reform laws. The Healthy North Carolina program would be targeted specifically for small businesses and sole proprietors. It would use government reinsurance to reduce the costs of a new private market health insurance plan for small employers, low-income individual workers, and self-employed individuals previously without health insurance coverage. It is expected that Healthy North Carolina would provide a 30% premium cost reduction over similar plans in the healthcare market, leading to health insurance coverage for approximately 33,500 currently uninsured North Carolinians.

The Task Force also recommended implementing a high-risk pool in North Carolina. There are many individuals with pre-existing conditions who work in or own a small business who would benefit from participation in a high-risk pool. A high-risk pool would control the premium costs of health insurance for individuals with greater health risk factors and take some of them out of the small group market. This could potentially have the effect of lowering the overall market risk and, thus, reducing costs for health insurance coverage in the small group market.

Another Task Force recommendation could benefit workers in small businesses through premium assistance for employer-sponsored insurance. The Task Force recommendation suggests expanding Medicaid to cover parents with incomes less than 200% of the federal poverty guidelines. Through this expansion and an associated waiver from the federal government, Medicaid-eligible parents could use state Medicaid funds to buy into their employers' health plans. As a result, this would help small businesses with low-income workers meet the plan

participation requirements of insurance carriers.

Tiered benefit plans were also recommended by the Task Force; however, there is some concern among small businesses regarding the potential this could have for reducing healthcare coverage to "bare bones" plans offering only minimal coverage. Catastrophic coverage is very important to a small business because if a small business owner experiences a serious health event without catastrophic coverage, it could result in the bankruptcy of the entire business. Therefore, unless tiered benefit plans were linked with catastrophic coverage, these plans would not be optimal for small businesses. However, even limited insurance coverage is preferred to none.

North Carolina must also steer clear of supporting association health plans. Association health plans are a way for small businesses to pool their employees to spread health risks across a larger group in order to access lower premiums for health insurance coverage. In North Carolina, association health plans are required to meet the state consumer protection laws outlined by the Department of Insurance, which includes specific mandated services. However, there is a new bill in Congress, S1955 Health Insurance Marketplace and Modernization and Affordability Act of 2006, introduced by Senators Michael Enzi and Ben Nelson, that would enact national standards for regulating and administering health insurance. This bill would favor small group rating laws that lead to larger premium variations charged to small employers.[17] As a result, insurers could avoid offering state-mandated benefits if they offered a benefit plan that includes the mandates covered by the state employee health plans of the five most populous states. As such, insurers offering non-state mandated plans could attract the healthier consumers, thereby increasing the average health risks for the population remaining in health plans with mandated benefits. This could lead to higher premium costs and continued loss of insurance coverage for the smallest businesses and businesses with the highest-risk workers.

At the state and national levels, there are a number of other policy options that could be beneficial to small employers, particularly in the form of tax incentives for businesses that offer and/or contribute to health insurance for their employees. House Bill 20 was introduced into the North Carolina General Assembly in 2005 by Representatives Holliman, Bordsen, Goforth, and Ross. The bill recommends providing a tax credit for small businesses that pay for at least 50% of health insurance premiums for all eligible employees.[18] At the national level, United States Senator Olympia Snowe recently introduced the "Small Business Health Insurance Relief Act of 2006" (S2457), which would provide tax incentives to small businesses offering health insurance coverage to their employees. In particular, the law would offer greater tax credits to the smallest businesses, which have fewer than ten employees, and enable small businesses to offer "cafeteria plans" with non-taxable benefits.[19]

In addition, both the House and Senate of the North Carolina General Assembly have discussed the idea of a Healthy North Carolina model, similar to the one recommended by the North Carolina Institute of Medicine Task Force. In the 2005-2006 Session, the Senate discussed a proposed committee substitute, which focused on a version of the Healthy North Carolina model. The House of Representatives Select Committee on Health also chose a Healthy North Carolina model as one of their recommendations from the full committee, making it eligible for consideration in the 2006 short session.

Every year, small business surveys indicate that health insurance coverage is one of the top issues of concern to North Carolina small business owners. Small businesses need to remain steadfast in their work to find effective and realistic ways to access more affordable health insurance coverage for their workers. Supporting the introduction of the Healthy North Carolina program and a high-risk pool are two of the most important efforts small businesses could make to affect change in the near-term. At the federal level, support for tax incentives could also offer some relief. Small business owners and employees make up more than a quarter of the state's workforce and face much greater challenges accessing health insurance than workers in larger firms. To continue to keep North Carolina's economy strong and supported by this workforce, greater access to healthcare should be made available to small businesses. **NCMedJ**

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COMMENTARY

North Carolina High-Risk Insurance Pools

David R. Moore, CLU

Imagine this: You are a 58-year-old man. You have worked all your life, paid taxes, and helped support your family. Two years ago you had a mild heart attack. Your wife has diabetes and high blood pressure. Luckily, you had health insurance through your job that helped you pay for the hospitalization, doctor's visits, and necessary medications for you and your wife. With a new diet, exercise, and the medications, you both are doing well managing your health problems. A little over a year ago, you lost your insurance when your company downsized. You found another job, but your current employer doesn't offer insurance. Your wife also works, but she works for a small employer that does not offer coverage. So, you pay approximately $600/month for continuation coverage (COBRA) for your wife and yourself through your former employer. Last month, you found out your COBRA coverage is about to end. You want to continue to buy insurance coverage, but you were told that purchasing a comprehensive policy with a $1,000 deductible (70% coinsurance) that covers your needed medications would cost more than $4,000/month for your wife and yourself.

All of us know people with health problems; these are the people who most need health insurance. But, have you ever stopped to think about how difficult or expensive it is to buy health insurance if you have pre-existing conditions? As a health and life insurance underwriter (independent insurance agent), I frequently work with families who want to buy health insurance, but have problems because of their past health history or ongoing health problems.

State and federal laws provide some protections for people who have health problems if they work for an employer who offers coverage. Under these laws, people with employer-based coverage cannot be charged higher premiums or excluded from coverage because of their pre-existing health problems. However, these same protections don't generally apply to individuals who want to purchase health insurance in the non-group market. There is currently only one insurer in North Carolina—Blue Cross and Blue Shield of North Carolina (BCBSNC)—that will cover anyone, regardless of their health status. However, the premiums charged are high, because people with pre-existing health problems typically incur greater than average healthcare costs. The premiums charged to people with the most serious health problems may be seven times higher than the premiums charged to a healthy individual. This premium is unaffordable to most families.

Thirty-three other states have established high-risk pools to offer comprehensive health insurance coverage to people with pre-existing health problems. These high-risk pools are similar to high-risk auto insurance. In North Carolina, individuals with poor driving records can purchase automobile insurance—at a higher rate—through the state's high-risk automobile pool. The pool is financed through premiums and an assessment on all of the automobile insurers in the state.

The states that offer high-risk health insurance typically cap the premium charged to families to make the coverage more affordable. Generally, the premium can be no more than 1.5 times (or 150%) of the standard rate charged to comparable healthy individuals.[a] However, because these premiums do not cover the full costs of the healthcare services that the insured high-risk individuals use, states pay for the deficits through assessments on insurance companies, state appropriations, or other means.[b,1] For the last five years, the North Carolina Health Underwriters Association has advocated that North

a Most states cap the premium at 150% of the standard rate; however, a few states allow premiums to be up to 200% of the standard rate. Health plans typically vary insurance premiums based on the person's age, gender, and geographic location. In a high-risk pool, the 150% cap would be based on a healthy person with a similar age and gender and living in the same geographic area of the state.

b Twenty-seven states finance the losses in their high-risk pool through an assessment on insurers. Of these, 11 states provide full or partial tax credits to offset the assessment, effectively shifting the costs back to the state. Seven states have a broad assessment on insurers, including commercial insurance carriers, stop-loss or reinsurance carriers, third-party administrators on a per-person/per-month basis. Two states pay for the losses through a surcharge on hospital bills, and five states use general revenues to fund their losses.[1]

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Carolina join the majority of other states and create a high-risk pool to provide affordable coverage to the people with pre-existing health problems.

Two bills have been introduced in the North Carolina General Assembly that would create a high-risk pool: HB 1895 (introduced by Representatives Insko, England, Nye, and Wright, with 28 other co-sponsors) and SB 1681 (introduced by Senator Purcell). The House Select Committee on Health and the North Carolina Institute of Medicine's Task Force on Covering the Uninsured supports similar legislation. While these bills may change as the legislation is debated in the General Assembly, the proposed legislation accomplishes the goal of providing more affordable health insurance to people with pre-existing health problems.

Under the introduced legislation, people with pre-existing health problems would be eligible for the pool if they had been turned down by two insurers due to pre-existing health problems, charged premiums by two insurers with higher rates than offered through the high-risk pool, or offered a health plan by two insurers with conditional riders that exclude coverage for the pre-existing health conditions. Individuals could also qualify if they have specific health problems that were identified by the plan administrators as eligible for coverage, such as HIV/AIDS. Certain other people who do not have pre-existing health problems can also purchase health insurance through the pool if they are unable to find better health insurance coverage in the private market. These include individuals who are guaranteed coverage in the non-group market under the federal Health Insurance Portability and Accountability Act (HIPAA) laws (described previously), or people who lost their insurance when their employer downsized or closed due to the Trade Adjustment Act.

Like most other states, the current legislation caps the premium at 150% of the standard rate charged by other insurers offering health insurance to individuals. Rates can be adjusted by age, sex, and geographic variation in claims cost in accordance with established actuary and underwriting practices. In addition, the bills that were introduced would also provide an additional premium subsidy for lower- or moderate-income families to help them afford their health insurance premiums.

The pool would offer several different plans, including Preferred Provider Organization (PPO) plans with different deductibles and cost-sharing levels and at least one high-deductible Health Savings Account plan (HSA).[c] The plans must include at least a $1 million lifetime limit and sliding-fee scale annual limit on out-of-pocket expenses of $2,000-$5,000 based on family income.

This is not the first time that high-risk pool legislation has been introduced in the North Carolina General Assembly. Similar legislation to either establish or study the need for a high-risk pool has been introduced at various times dating back to the 1980s. Historically, the major stumbling block has been the mechanism to finance the uncovered claims costs (e.g., the healthcare costs that are in excess of the premiums collected). Insurance companies have opposed past attempts to finance the uncovered costs through assessments on covered lives. They were concerned that an assessment focused solely on commercial insurance companies, like Blue Cross and Blue Sheild of North Carolina, United Healthcare, Cigna, Wellpath, Fortis, and all other providers of health insurance products in North Carolina, would raise the costs of their premiums, leading more employer groups to self-insure in order to avoid paying the assessment. Provider groups similarly opposed any attempts to cover losses through a provider assessment, arguing that the assessment was nothing more than a "sick-tax" (e.g., tax on sick people). The General Assembly has never been willing to appropriate state funds to finance a high-risk pool.

"Many of these individuals want to buy health insurance, but can't afford the policies that currently exist."

This year, the legislation is structured differently. Instead of singling out any one group to bear the burden of financing the losses, the legislation spreads the burden across multiple groups. The bill limits provider reimbursement to the Medicare rates, which is lower than what is typically paid through commercial insurance plans. By accepting this lower reimbursement, providers help by lowering overall healthcare costs and therefore, the amount of financial loss to the plan. The proposed legislation also assesses insurers to help pay for the losses. However, unlike past attempts that focused the assessment on commercially insured plans, this legislation calls for a broader-based assessment on commercially insured plans, multiple employer welfare arrangements (MEWAs), third-party administrators (TPAs), administrative service organizations (ASOs), and reinsurers. This helps spread the costs to employer groups that purchase health insurance through commercial insurers, and indirectly, to those who self-insure (by assessing third-party administrators or reinsurers). The legislation also calls for a general appropriation to help subsidize the costs of insurance coverage for lower-income or moderate-income individuals. Congress also appropriated $75 million annually through 2010 to help states offset some of the losses incurred in high-risk pools, and another $15 million to provide

c A Health Savings Account is a high-deductible health plan combined with a pretax savings account. Both employers and employees can contribute to the savings account with pretax dollars. Individuals can withdraw funds from the savings account to pay for healthcare expenses up to the deductible amount.

grants of up to $1 million to help states, like North Carolina, establish a high-risk pool.[2]

Making health insurance coverage affordable to people with pre-existing health problems is not only the "right thing to do," it is also a smart investment. People who have chronic illnesses or other serious health problems (such as cancer) are more likely than healthier people to need healthcare services. Many of these individuals want to buy health insurance, but can't afford the policies that currently exist. So instead of creating a health insurance product that captures the premium dollars these people are able to afford, we force many people to go without insurance coverage. Without insurance, they are more likely to forgo the care they need to manage their health problems, and their health suffers as a result. Many end up in the hospital with problems that could have been prevented, with no way to pay for the outstanding hospital bills. Large outstanding healthcare bills (often caused by lack of insurance coverage) is one of the primary reasons that people go into bankruptcy.[3] This affects not only the individual family and specific healthcare providers, but other creditors as well. Further, all of us who have health insurance pay higher premiums to help cover the costs of services provided to the uninsured. Thus, by creating an affordable insurance product for those with prior health problems, we both make it easier for these individuals to obtain needed health services in a timely way in an appropriate—and hopefully less costly—setting, but also help capture the funds these individuals can afford to pay for needed healthcare services. **NCMedJ**

> *"The premiums charged to people with the most serious health problems may be seven times higher than the premiums charged to a healthy individual."*

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Advocating for Healthcare

In 1983, I began a journey that taught me the inadequacies of the health insurance industry. My daughter was born with a birth defect known as microtia. Within 18 months of her birth, my husband became unemployed, and as a result, we lost our health insurance coverage. My husband found employment in North Carolina, and we moved in 1985. During this time, I spent countless hours researching microtia and seeking medical care for my daughter.

In 1989, I finally found doctors who could care for my daughter, and I thought our troubles were over. However, we were quickly denied coverage because she wasn't born on the health insurance plan that we were now under. The reality was that the insurance plan included a clause that exempted all claims for a child with a birth defect unless the child was born under the plan. This was not a pre-existing clause that would give coverage after a period of time, but a clause that prohibited payment at any time for that defect. We chose to fight the claim denial since we had not been able to secure a proper diagnosis for our daughter previously, and the surgery that she needed was not usually done prior to the age of seven years. With the help of our daughter's doctors, we advocated for her care and won our case. Once again, we believed our troubles were over since our daughter was going to receive her much needed medical care. We hoped that this chapter of our life was closing, and life would move on.

As life would have it, in the next few years my husband was laid off from his job again. In a funny coincidence the company he was working for (a small business with less than ten employees) was denied health insurance coverage. One week after his lay-off, the company secured health insurance coverage. Tired of living through unemployment at life's twists and turns, we decided to open our own business. We thought that we had taken control of our own fate, but now we became our own small group seeking health insurance coverage. This presented a challenge all it's own without having the additional difficulty of a child with a congenital defect.

During the ten years we owned our business, we were never able to obtain health insurance for two main reasons:

- The cost was prohibitive—in the mid-1990s, I received quotes for health insurance for our family that were between $800-$1,000 per month.
- We were asked to sign a waiver that stated we would not seek coverage for anything related to our daughter's birth defect.

After our previous experience with insurance claims, we were not comfortable signing an agreement that gave up our daughter's right to coverage for her medical condition, and as a result, we weren't insurable. In the end, we resolved the situation by closing our business. Our overwhelming concerns for our family's health lead us to seek employment with large employers where our daughter's condition would not be a factor in health insurance coverage. We knew we had an overwhelming obligation to our entire family and how devastating a medical emergency could be financially. We went through a difficult transition as we adjusted to less monthly income, but we felt more secure knowing that our children were now protected by a health insurance plan.

Today, we are glad that our situation has been resolved. However, I continue to be greatly concerned about healthcare in the United States and the countless others who are not able to find alternate employment to reconcile issues such as these. Everyday, I hear the concerns of others who are struggling with insurance issues and finding it increasingly difficult to maintain their families' financial and physical health.

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COMMENTARY

Insuring North Carolina's Working Poor:
Building the Foundation

L. Allen Dobson, MD

The work of the Covering the Uninsured Task Force of the North Carolina Institute of Medicine and the subject of this Journal forum is extremely timely and focuses on maybe the most important healthcare issue facing our state in decades. Basic affordable healthcare is essential to the health of our state, our citizens, and our economic future. There are no simple solutions, but we must start now building the foundation programs that will allow us to assure all our citizens have access to needed basic healthcare and affordable health insurance in the future.

North Carolina has made great strides over the past decade in providing health insurance for our states poorest children through expansion of our Medicaid and Health Choice programs. Medicaid, while covering over 800,000 North Carolina children and mothers, also serves a vital role in providing care for our 400,000 poor elderly and disabled citizens. Despite recent difficult economic times and severe state budget shortfalls, North Carolina has avoided many of the draconian cuts and eligibility reductions experienced in other states. While North Carolina has not been forced to exercise major cuts to its Medicaid program, controlling Medicaid spending remains a top priority. Through expanding our successful Community Care of North Carolina program statewide and inclusion of the aged, blind, and disabled Medicaid recipients in our clinical management strategies, we can reduce the rate of expenditure growth in the Medicaid program without sacrificing quality or access to needed services. Community Care networks are now well organized regional networks of physicians, hospitals, health departments, and social service agencies charged with developing improved local systems of care for Medicaid recipients focusing on quality, disease management, and targeted utilization initiatives. This public-private partnership between the Department of Health and Human Services and community providers has produced needed savings, slowed the Medicaid growth rate, and improved the quality of care provided to our Medicaid recipients.

As we focus on exploring low-cost options for providing health insurance to more of our citizens, it is important to support and expand the fragile safety net of providers available to our poorest citizens without insurance until coverage is available to all. Increased funding to these traditional providers, such as community health centers, public health departments, rural health clinics, and free clinics, is needed to help meet the needs of poor citizens. The care of the poor and uninsured, however, can not be left solely to these providers. A coordinated, community system of free care is needed until we are able to provide more of our citizens with affordable health insurance. The success of Project Access in Asheville and the many similar projects across the state, initially funded by federal Healthy Community

"As we focus on exploring low-cost options for providing health insurance to more of our citizens, it is important to support and expand the fragile safety net of providers available to our poorest citizens without insurance until coverage is available to all."

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Access Program (HCAP) grants, illustrates the importance and often unstated role of private physicians in the community safety net. The success of these community efforts to include private primary care access as well as traditional safety net providers in an organized system has successfully expanded the capacity of the system to care for the poor without significant increases in funding. Providing basic primary care through these community-organized systems prevents delay in needed care and often more serious, costly, and unnecessary complications.

This Journal expertly outlines the many options available for expanding affordable health insurance to many more North Carolinians. While the task of covering everyone seems daunting, the recent announcement of the Massachusetts federal waiver approval that creates state-subsidized insurance for low-income working adults and also mandates health insurance for all citizens should illustrate that universal coverage is possible to achieve. Each option presented by the North Carolina Institute of Medicine Task Force on Covering the Uninsured report, *Expanding Health Insurance Coverage to More North Carolinians*[1] is important in providing insurance to different populations of citizens who have no insurance. While Medicaid and North Carolina Health Choice provide health insurance for many of our poorest children, their parents are often uninsured. Childless adults, no matter how poor, have no options for coverage. Many working citizens simply cannot afford the cost of health insurance. It is clear that no one strategy alone will provide for everyone. We must start small, recognizing that there are not sufficient funds available to accomplish the task of full coverage immediately. Long-term success will come from developing programs that also include quality improvement, disease management, and utilization management as important components to assure that the cost of new programs do not grow at a rate that would jeopardize their future. Community Care of North Carolina has shown that such strategies, when implemented locally, can save money while improving quality.

As additional savings are realized in our Medicaid program, it will be important to reinvest some of those savings in building the foundation programs to expand health insurance to all North Carolinians. Building the foundation for providing affordable health insurance for all of our citizens will require a continuing dialog and a strong commitment not only from government, but also businesses, healthcare providers, and citizens. We must start now. It is time for North Carolina step forward to assure healthcare for all of our citizens. **NCMedJ**

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COMMENTARY

Public Policy Options for Small Employer Health Insurance

Barbara Morales Burke, MHA

Despite the fact that fewer people are covered under an employer health plan than have been in the past, employer-based insurance is and likely will remain the cornerstone of our health insurance system for the foreseeable future. Employees of small firms are less likely than employees of large firms to be offered insurance through their job and, as a result, more likely to be uninsured. For example, data from the 2002-2003 Medical Expenditure Panel Survey showed that only 57.2% of employees working in firms with fewer than 50 employees were offered health insurance. Small firms employ a significant portion of North Carolina's workforce, so the lack of insurance among these firms is a serious public policy concern. Policy options aimed at improving our rate of insured among employees of small firms can and should be considered.

Before considering these options, it is useful to understand certain aspects of North Carolina's regulation of small group health insurance premiums. Premiums for small employer groups (those ranging in size from self-employed individuals up to firms with as many as 50 employees) are set using a methodology known as "adjusted community rating with rate bands." The "community rate" is the statewide expected per-person annual claims cost for an insurer's entire book of small group business. The "adjusted community rate" is the differentiation in premium costs from the community rate for a particular small group, based on the small group's "case characteristics," which are defined as age, sex, family composition, and geographic location.

Using the community rate creates a substantial subsidy effect on the premiums charged to groups whose members have higher than average medical risk, because the premium rate for all small group insureds, regardless of risk status, is generated from the same starting point. In other words, higher-risk groups benefit from subsidies because the costs are spread across the groups that are less costly to insure. Working from the community rate, each small employer's premium is adjusted to reflect their differences in expected medical costs due to case characteristics and the specific benefit plan chosen. In addition, premiums are permitted to differ—up to 20%—based on the estimated medical risk of the specific group. Thus, North Carolina laws governing small group health insurance premiums reflect a balance of three rating philosophies: a substantial subsidy effect for groups with higher medical risks, full differentiation based on demographics, and limited differentiation based on medical risk.

"Small group regulation cannot be adjusted to produce dramatic change because [it] is based on cost shifting..."

Potential Changes to Current Small Group Regulation

Small group regulation cannot be adjusted to produce dramatic changes because this regulation is based on cost shifting rather than the underlying healthcare costs that influence insurance premiums. However, some pricing improvements can be achieved through modest adjustments to current law.

Some employers and interest groups advocate for increasing the subsidy effect for the higher-risk employees, while others advocate for reducing the subsidy effect so coverage wouldn't be too expensive for lower-risk employees. A change to our current system will create undesirable tradeoffs at either extreme since it is based on a cost-shifting approach. Because increasing the subsidy effect produced by the rating process shifts more expense to employers and employees who have fewer health risks, fewer employers will be able to afford the higher-cost insurance, and the youngest and healthiest employees offered coverage on the job may decide it is not a good value and opt out. As those with fewer health risks (i.e., the number of those who cost the least insure) leave the market, the community rate

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rises. Therefore, in reality, increasing the subsidy effect too much would actually produce the opposite of the effect intended—it would inadvertently lead to a lower subsidy effect because there are fewer healthy people in the group to diffuse the costs incurred by those with higher health risks. On the other hand, a rating system that extracts a smaller subsidy from the low-risk groups would increase the likelihood that coverage would become prohibitively expensive for the high-risk groups. Therefore, too great a decrease to the subsidy effect would benefit only the healthiest people and would cause higher numbers of uninsured among less healthy employees. A balance between [these opposing forces] providing a sufficient subsidy effect to help those who cost the most to cover, but not so much subsidy that it drives the low-risk employees out of the market—produces the most beneficial overall results from a public policy standpoint.

The North Carolina Department of Insurance (NCDOI) recently recommended to the North Carolina General Assembly House's Select Committee on Health Care adjustments to the state small group rating laws that would reduce premiums for groups with lower medical risks or certain demographic factors that make them less costly to cover. These changes would result in a modest decrease in the subsidy effect for groups with higher medical risks or certain demographic factors that make them more costly to cover. An additional effect of these changes would be *lowering* premiums or to reducing premium increases for all small groups. This would occur because more lower-risk employees would be able to buy and retain coverage, which would depress the average claims cost and boost the subsidy effect that the community rate has for higher-risk employees. This latter effect is the reason that NCDOI recommends these rating changes.

Some state and federal legislation—most notably bills proposing special treatment for association groups[a]—purport to reduce the high cost of health insurance for small groups. However, these approaches have been flawed due to the fact that they would reduce (or eliminate completely, by fragmenting the small group market) the subsidy effect for higher-cost small employers without providing any offsetting benefit to these groups. Some of these proposals go even further, suggesting the deregulation of association health plans, which would create an un-level playing field within the market and deprive some citizens of consumer protections under state law. As a result, lack of insurance would become an even greater problem for employers whose employees are higher-risk. Association health plans are not a part of the solution for small employers.

New Product Options

New health insurance products may keep coverage affordable for employers who currently offer health insurance coverage to their employees. These products may also appeal to some employers and individuals currently unable to afford to offer or buy coverage. Examples of these products include: high-deductible health plans offered alone or in conjunction with health savings accounts, "limited benefit plans" that cover a certain amount of costs up-front or after meeting a high deductible, and so-called "tiered benefit plans" where an employer contributes toward a base plan with the option for employees to "buy up" to a richer plan. In a few cases, a change to state law would be required to allow these products to be offered or to enable these products to function as intended; in other cases, insurers can and do offer them now.

Proliferation of plans that provide less coverage raises concerns over the financial barriers to obtaining necessary care and whether some employers now offering more comprehensive plans will "trade down." But the reality is, without alternatives, some employers who currently offer coverage may drop it in the future due to cost, and people who cannot afford coverage now will continue not to have any options. A more pressing concern is that these products actually offer value to someone who presently does not have insurance; without value, these products will not even provide incremental improvement in the numbers of uninsured among employees of small firms.

Realistically, alternative products are needed as a part of any multi-pronged approach to sustaining and expanding the small group market. Although tempting from a public policy standpoint, placing limitations on the sale of certain products in an attempt to prevent them from being substituted for more generous coverage is not practical, since there is no way to identify employers or employees who would have to drop coverage due to cost in a future period, but for having the ability to switch to an alternative product. However, requirements can and should be used to preclude the offering of alternative products in a way that subverts small group regulation.

Additional Ways to Subsidize the Cost of Coverage

Because health insurance premiums are simply unaffordable for some employers and employees, additional forms of subsidy may be required to enable some to buy or continue to buy insurance at its present true cost. Attention in our state has focused on tax credits for employers offering coverage and on a program (dubbed "Healthy North Carolina") offering coverage reinsured[b] by the state. Ideas for other, more simple subsidy mechanisms should also be considered.

Tax credits for employers' contributions toward health insurance may help some employers continue to afford offering coverage when they might not otherwise be able to do so. Critics of tax credits rightly point out that credits will reward employers who would offer coverage even without a credit, and therefore are not an efficient use of state funds. Targeted credits, such as credits for employers with lower-paid employees or those not currently offering coverage could be a more effective

a Association Health Plans are groups of small employers pooling together to self-insure.

tool to contain or decrease the ranks of the uninsured.

The Healthy North Carolina proposal, modeled after an existing program in New York state, would rely upon state-provided reinsurance to reduce the level of premiums that insurers would charge eligible employers and workers for coverage. For this program to work in North Carolina, key differences between this state's and New York's insurance market must be addressed. Funding for the reinsurance needs to be both adequate and reliable in order to have the desired effect on premiums. Premiums and benefits need to appeal to the target population. Eligibility and other program rules need to be set in such a way as to avoid attracting only high-risk groups to the program and also avoid causing erosion of the existing small group insurance market. Even with all of these conditions satisfied, the opportunity to buy health insurance at subsidized rates does not guarantee increased uptake among small employers and employees. However, if there is the will to use state funds for a program such as this, the task of properly structuring it is doable, and the opportunity to thoroughly explore this option should not be passed up.

Addressing the Cost of Medical Care

Although the other policy options discussed here may present some opportunity to reduce the net (or effective) premium costs paid by small employers and their employees, they do not address the primary driver of the cost of health insurance—the cost of the medical care that the insureds receive. Containing the cost of care will entail employing a wide variety of tactics to exploit numerous opportunities for improvement. Chief among these are reducing the amount and level of care needed through promotion of healthy lifestyles, better disease management, and improved treatment protocols. The full impact of initiatives to address these and the other factors fueling the growth of healthcare costs will not be realized all at once or in the short-term. However, tackling medical costs is the only way to achieve meaningful, sustained improvements to the insurance market as a whole.

Conclusion

The small group health insurance market in North Carolina can be improved through a number of policy approaches that can work individually or in combination.

- First and foremost, maintain the basic framework of our current small group regulation. Do not allow or support changes to small group regulation that would fragment the market and benefit only the healthiest workers. This is necessary regardless of any other policies adopted.
- Make adjustments to the details of small group rating law as recommended by the Department of Insurance, in order to realize modest beneficial effects on premiums.

"The small group health insurance market in North Carolina can be improved through a number of policy approaches that can work individually or in combination."

- Allow insurers to offer alternative benefit plans that can help employers continue to afford offering insurance and appeal to some of those employers and employees in the small group market who do not currently offer or buy coverage. Do not allow or encourage products that would undermine the small group market by circumventing small group regulation.
- Use state fiscal policy to subsidize the cost of coverage in order to help employers who currently offer coverage to continue offering it, and enable or encourage employers who are not offering coverage to do so. Target these funds to help those most at risk of having to drop coverage due to cost and those who are the least able to afford insurance today. Make sure that no mechanism used to provide subsidies has a harmful effect on the small group market.
- Implement policy and support specific initiatives to reduce the total cost of medical care provided over the long term.
- Take actions aimed at reducing the numbers of uninsured outside of the small group market that also have a positive impact on small groups. Examples include approving a limited expansion of Medicaid for low-wage workers so that the burden of uncompensated care on all (including the small group market) will be reduced, and establishing a high-risk pool for individual coverage so that removing self-employed individuals (the most risky of all small groups to cover) from the small group market can be considered as an option in the future, and the cost of subsidizing these costly groups can be spread beyond the small group market. **NCMedJ**

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b Reinsurance is essentially insurance coverage for insurance carriers. If the annual claims for an individual in the plan reach some predetermined amount, then the reinsurer covers at least some part of the claims above that level.

COMMENTARY

Controlling Healthcare Costs:
The Key to Making Coverage Affordable

Robert J. Greczyn, Jr.

Never before in our history have Americans enjoyed such a wealth of healthcare options. The diagnosis, treatment, and cure of illness and disease have rapidly improved in recent history, thanks to groundbreaking research, blockbuster drugs, and technological innovations.

But the seemingly unlimited care and treatment options we have grown to rely on come at a price—to us individually and as a society. For those with health insurance, it takes an increasingly large chunk of each paycheck to cover insurance premiums and medical care. For those without insurance, the cost of their care is left to taxpayers and paying customers, and that burden is growing larger every year.

We're at a point in time in which we can no longer continue business as usual in our healthcare system. As health costs continue their upward march, attention is squarely—and rightly—focused on what can be done to expand access to medical care. The health insurance industry is actively engaged in developing solutions to the growing problem of the uninsured, both in North Carolina and across the nation.

The Root Cause

The collective cost of medical procedures, drugs, and devices has risen to the point that the United States now spends 16% of gross domestic product (GDP) on healthcare,[1] which is more than ever before. One reason is demographic: our population is older, with a vast cohort of baby boomers reaching 60 this year. Perhaps more important from a public health standpoint, our society continues to engage in unhealthy living. Poor diet, lack of physical activity, and tobacco use are driving up healthcare costs.

The price we pay for this lifestyle is increased rates of costly chronic illnesses, such as heart disease, cancer, and diabetes. Obesity rates have skyrocketed in adults and in children, with frightening consequences. Once a rarity among children, Type II diabetes (in a simpler era called "adult onset diabetes") is occurring more frequently and condemning children to a life of poor health and increased healthcare costs. We all share in the cost of treating an unhealthy society.

For Blue Cross and Blue Shield of North Carolina (BCBSNC), the unhealthy segment of our membership has a greater impact on our total costs. Our data show that 80% of our costs are driven by only 18% of our members.[2] This puts tremendous pressure on the insurance system, driving premiums up at a faster rate than earnings for employers or their workers. This cost crunch inevitably shrinks the percentage of businesses that offer insurance benefits to their employees. In the end, we cannot broaden access to health insurance without a solid plan for addressing underlying cost pressures in healthcare.

"Never before in our history have Americans enjoyed such a wealth of healthcare options."

Some say that higher healthcare costs are a good trade-off for getting the best and most up-to-date medical care. We pay more because medical care is so much better, so what's the problem? One of the most frustrating aspects of the United States' cost spiral is that, although we spend more per person on healthcare than any other nation, we are far from the healthiest nation. By various measures, including data from the World Health Organization, the United States ranks about 30th in the world for the health of its people. We don't seem to be getting value from all the additional dollars pouring into healthcare.

Insurers' Response

To address the uninsured problem, the question we must ultimately ask is, "What can we do to stem the tide of rising healthcare costs to make coverage affordable for more people?"

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There is no simple answer, and progress clearly depends on individuals, families, insurers, employers, providers, government, public health—all healthcare stakeholders—working together. It will also require a sea change in how we value preventive medicine in relation to more reactive care.

Insurers grapple with how to be involved in this long-term process while still delivering cost-effective insurance products that meet customer needs today. We have to balance investment in new approaches with the likelihood that our customers will see a reasonable return on these investments. Some health promotion efforts accrue benefits to our members immediately. Others take time to realize. Efforts to educate patients with diabetes or asthma, for example, on how to take better care of themselves provide a quicker return by reducing the need for emergency room visits and hospital stays. The payback on heart disease, meanwhile, is more long-term.

One new trend among insurers is the movement to consumer-directed health plans. These plans offer coverage at lower premiums but with higher deductibles, giving consumers more choices in designing and paying for a health plan. One of the most promising aspects of consumer-directed healthcare is Health Savings Accounts (HSAs) that pair health coverage with tax-advantaged savings accounts to pay for medical care. HSAs can also be designed to cover limited preventive health services at no charge.

For the consumer-directed model to succeed, patients will need to not only engage in purchasing decisions—based on information from their physicians, insurers, and other sources—but they'll also need to change their behavior. In our current model, consumers tend to act on what their doctors recommend, with the understanding that their insurer will pick up the tab. The consumer-driven approach says that patients are more in charge of their own care since they have a greater financial stake through higher deductibles, health savings accounts, and other methods of paying for the services provided.

In another change, insurers have found success in helping consumers reduce their costs by promoting the use of generic prescription drugs. Generics are equal to brand-name drugs in active ingredients, yet cost 30% to 70% less.[3] Blue Cross and Blue Shield of North Carolina instituted programs waiving co-payments on generic prescriptions for our members in late 2004 and early 2006, encouraging them to make the switch from brand-name drugs to more cost-effective generic substitutes. Over a three-month period in 2004, BCBSNC members collectively saved approximately $17.6 million in out-of-pocket costs.[3] But there are also long-term benefits: about 22% of members stayed with generics,[3] leading to significant savings in coming years. Our challenge now is to show physicians the value of generics when appropriate for their patients so that the cost advantages can be spread to all patients, not just BCBSNC members.

Additional efforts in North Carolina show promise for a long-term payoff. As the largest health insurer in the state, BCBSNC in 2000 established a foundation to address health needs in North Carolina. Two years ago the Blue Cross and Blue Shield of North Carolina Foundation entered into a five-year, $10 million partnership with the North Carolina Association of Free Clinics to sustain and expand the free health clinic model throughout North Carolina. Funds from the Foundation already have allowed six new clinics to open. By the end of the five-year period, the capacity of free health clinics to serve the uninsured in North Carolina is expected to double.

In another partnership, the BCBSNC Foundation is contributing to the expansion of the Community Practitioner Program run by the North Carolina Medical Society Foundation. The goal of this $10 million grant by the BCBSNC Foundation—which triggered $5 million in matching funds from the Medical Society Foundation—is to help place primary care physicians and nurse practitioners in underserved areas of North Carolina, such as rural areas and inner cities with few medical providers, and keep them there.

Consumer Awareness

One of our challenges is to help make consumers more aware of the true costs of healthcare in today's world. For many, healthcare costs begin with the insurance premium and end with a small co-payment or deductible. This means there is little understanding of the actual costs of physician services, hospital care, or drug treatments.

This disconnect between costs and services undermines market forces that exist in other sectors of our economy. The result is that medical services may be overutilized, or at the very least, that care is not delivered in the most cost-effective way. For example, doctors and patients alike are focused on treating diseases and conditions after they emerge. But there's much less focus on preventive health, counseling, and lifestyle changes that could head off serious health problems before they ever develop.

Enabling consumers to connect costs to medical care could go a long way to helping individuals determine the wisest use of their money. Online services offered by many health insurers, including BCBSNC, let consumers see the costs of various medical services and treatments.

Another method is to measure and present data on the quality of healthcare, which serves dual goals of providing incentives for physicians and hospitals to deliver high-quality care and allowing consumers to see which providers do the best job. As employer-led quality initiatives such as Bridges to Excellence (for physicians) and Leapfrog (for hospitals) gain acceptance, the thinking is that quality incentives will help mitigate rising healthcare costs by shifting the focus to preventive care and reducing the likelihood of costly medical errors and complications.

Beyond educating consumers on the wise use of healthcare benefits, it also must be a primary goal to build awareness of how personal lifestyle choices drive costs in the system. While many Americans understand that an unhealthy lifestyle can lead to obesity, heart disease, and diabetes, few make the leap to connecting increased costs to those lifestyle choices.

North Carolina is facing a growing crisis when it comes to obesity. Obesity-related problems cost North Carolina employers

an estimated $3,000 per employee in rising healthcare costs and absenteeism.[3] There is ample evidence in BCBSNC data that overweight individuals have significantly higher medical costs. Still, few individuals seem to make the connection that unhealthy lifestyles cause premiums—including the employee-contributed portion—to rise. While Americans expect the best available care, wide freedom of choice, and access to cutting-edge technology, we often do not take ownership of our own lifestyles.

When it comes to car insurance, the safest vehicle—as judged by accident data—is the least expensive to insure. With homeowners insurance, smoke detectors, burglar alarms, and other preventive devices can help lower your premium. Shouldn't we encourage individuals to show the same respect toward our bodies and our families as we do our possessions?

Collaboration Is Key

While it will be extremely difficult to reduce overall healthcare expenditures and thus increase access to healthcare, by working together we can help slow the rate at which healthcare costs are rising. Although no easy task, this is the key to keeping health coverage affordable.

Insurers can work with providers to develop incentives for preventive care, for example. Employers can work with public officials to design workplaces and communities that encourage physical activity. Health plans can respond to consumer needs by offering coverage designed to fit an individual's specific needs. The list of steps that can make a difference is a long one.

In the end, our challenge goes beyond financial. Reducing cost is a big part of the picture, but it's only a means to an end. The ultimate goal is a healthier North Carolina, one whose residents enjoy longer, happier and more productive lives. By reducing costs—especially for costly chronic diseases—we can also ensure the long-term availability of affordable coverage.

A healthy North Carolina is what it's all about. After all, it's our home. **NCMedJ**

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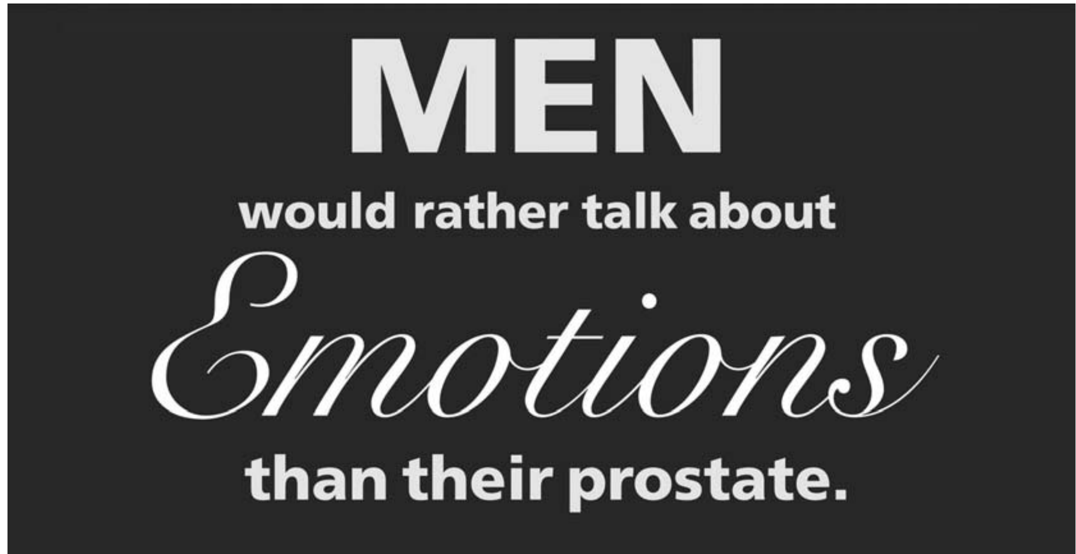

One in six men will be diagnosed with prostate cancer in his lifetime. The good news is, it's highly treatable, if you find it early. If you're 50 or older, speak with your doctor about getting tested.

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COMMENTARY

Insuring North Carolina's Children

E. Stephen Edwards, MD, FAAP

Quality health insurance for all North Carolina children has been a long-term goal of the North Carolina Pediatric Society (NCPS). Currently 265,000 children under the age of 18 remain uninsured. Two thirds of this number are eligible for either Medicaid or North Carolina Health Choice, the State Child Health Insurance Program. Thus, there are approximately 85,000 North Carolina children who are both uninsured and ineligible for current public insurance programs.

Leaders of the NCPS along with other child advocates and political leaders are exploring options to insure these children. Should there be a state subsidy for children in families with incomes above 200% of the federal poverty guidelines (FPG) or $40,000 for a family of four? If so, should there be a sliding-fee scale, and what should those rates be? At what level should that scale end (300% or 400% FPG)? How could we best assure that there would not be a "crowd out" effect where currently insured children would transfer from private plans to state-offered plans? While the assumption is that co-payments would be required for those above 200% FPG, how much should those co-payments be? Should immigrant children who are ineligible for federal subsidies be offered state subsidies?

One of the most difficult questions involves the benefit package. Currently the benefit package for Medicaid and North Carolina Health Choice is very comprehensive, including preventive healthcare; sick child care; therapy for hearing, speech, and visual problems; and dental and mental health problems. Can we afford that same package for the working poor?

Our state's Enhanced Case Management System has worked well in the Medicaid and North Carolina Health Choice populations to reduce expenditures. It has improved the health of children with chronic diseases, such as diabetes and asthma, while reducing costs by decreasing emergency room and hospital usage. Should that be extended to this new group of insured?

Physician fees have to be considered. In North Carolina, Medicaid and North Carolina Health Choice payments for services to children are 95% of Medicare-allowable fees. By national standards this is generous, but with expanded numbers of children covered by the program, will those who care for children be able to stay afloat financially? This will be of special concern if the "crowd out" factor pushes more children from private insurance to the state program. (My impression is that our adult medical colleagues aren't very happy even with 100% of

"Currently 265,000 children under the age of 18 remain uninsured. Two thirds of this number are eligible for either Medicaid or North Carolina Health Choice, the State Child Health Insurance Program. Thus, there are approximately 85,000 North Carolina children who are both uninsured and ineligible for current public insurance programs."

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Medicare-allowable fees.) We certainly don't want to create programs that financially punish healthcare professionals who participate.

And, finally, how do we pay for the system? In Massachusetts, where an individual mandate law has just been signed by Governor Romney, some contend that there is already enough money in the system to finance healthcare for all. This remains to be demonstrated. In North Carolina, at least initially, additional funds would be required from state appropriations. Where would we get those dollars? Are there creative ways to bring more federal dollars to North Carolina by increasing the ceiling for Medicaid and North Carolina Health Choice above 200% FPG?

These are just some of the questions that are being explored by the NCPS and others interested in child health—and they are important questions. These questions could be resolved rapidly if there were indications that we are ready for change. As a society we have committed to nutrition and education for all children. How long can we continue to ignore child health? Data are available to show that uninsured children fail in multiple facets of life, such as missed school days and poor school performance.

We live in the richest society in the world. We tried the employer mandate route in 1990 with the Matsui Bill and in 1993 with the Clinton health plan. There was vigorous objection to both, especially from the business and insurance sectors. Massachusetts has now adopted an individual mandate where each citizen is required to purchase health insurance. We adopt a somewhat similar program for automobile liability insurance. Is the health of our children not more important than our automobiles?

There are obviously some difficult questions of equity and financing involved in health insurance for all children. But a nation that sent men to the moon with a single decade's effort is smart enough and rich enough to provide health insurance for our children. What we lack is not the money, nor the brain power, but the WILL.

If we choose to establish child health as priority, implementation could be accomplished quickly and relatively inexpensively. While the NCPS has focused primarily on child health, I believe that the organization would enthusiastically join any coalition to promote health insurance for all North Carolinians. **NCMedJ**

COMMENTARY

It's Not the Uninsured, Stupid:
Two Hurdles on the Track to Affordable Healthcare Coverage for All in North Carolina

Adam G. Searing, JD, MPH

Moving North Carolina policy toward affordable healthcare coverage for all requires dealing with two problems ignored by many people and organizations interested in this issue. First, the dominant way stories about lack of affordable healthcare coverage are portrayed in the media is helping to stifle efforts for reform. Contrary to conventional wisdom, so-called healthcare horror stories—far from being helpful in showing the need for reform—focus attention on individuals rather than systemic solutions while insulating political leaders from responsibility. Changing the conversation about healthcare reform isn't enough, however. The second problem lies in irresponsibility on the part of the federal government that has resulted in huge tax cuts aimed largely at the wealthiest Americans, an exploding federal budget deficit, and consequent current and future cutbacks in existing healthcare programs like Medicaid and Medicare. If we can't maintain our current healthcare coverage, the prospect of bringing more people into the current healthcare coverage system is remote indeed.

The Healthcare Horror Story Doesn't Work

A common media tactic used for years when health policy analysts, advocates, policy makers, and others attempt to "address the problem of the uninsured" is to rely on the story of the Medicaid recipient struggling to make ends meet while living with a serious disability, or the mechanic who makes a decent living, but not quite enough to afford health insurance for his family. Advocacy organizations[1] compile "story banks" of these sorts of healthcare failure stories for distribution to reporters. Health policy textbooks highlight the "horror story" illustrative tactic for students.[2] The media actively looks for these sorts of stories and frequently inquires if health clinics, hospitals, doctors, and others know someone without insurance who is willing to tell their story.

The prospect of such healthcare horror stories regularly sparks dread among targeted industries and politicians. For example, filmmaker, Michael Moore, is collecting healthcare horror stories for a new film on the uninsured and America's healthcare system. The pharmaceutical industry is especially worried: "For every horror story Michael Moore produces, we can produce 1,000 success stories, but he's not interested in them," said Ken Johnson, the senior vice-president of the trade group Pharmaceutical Research and Manufacturers of America."[3]

Despite fear from the targeted and enthusiasm from the mobilized, the idea underlying the healthcare horror story—that evoking sympathy with a story of hardship or poverty will translate into support for change in policy—has been shown to be dead wrong. Such stories even have the opposite effect by depressing support for changes in policy and diverting attention from the real problems. After seeing a healthcare horror story, people tend to think of the problem of the uninsured as that particular family's or individual's problem and not a problem that can be solved by government. The focus on the story shifts the focus away from the responsibility of politicians, as leaders of government, to act and address the problem for everyone.

"...refocusing media attention from the individual story of the poor uninsured person to the systemic problems that underlie the lack of affordable healthcare should be a top priority."

The idea that "horror stories" might not be so effective was first raised in the 1980s when Shanto Iyengar and Donald

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Kinder published *News that Matters*,[4] a critical look at the rise of television news and its effect on policy agenda setting. Conducting multiple experiments they determined that:

> [C]ontrary to much conventional wisdom, news stories that direct viewers' attention to the flesh and blood victims of national problems prove no more persuasive than news stories that cover national problems impersonally—indeed, they tend to be less persuasive. This undermining of agenda-setting may be particularly powerful when viewers in effect blame the victims for the problems that have befallen them. Perhaps visual presentations are generally less persuasive in part because they are so successful as melodrama. Viewers may get so caught up in one family's troubles that they fail to make the connection back to the national condition. Overwhelmed by concrete details, they miss the general point.[5]

Iyengar expanded on this work with more research. In addition to confirming his earlier views, he found that such "episodic framing," or focusing on individual stories and not the bigger picture, also insulated politicians and other public officials from responsibility for fixing the problems. Iyengar writes, "By simplifying complex issues to the level of anecdotal evidence, television news leads viewers to issue-specific attributions of responsibility, and these attributions tend to shield society and government from responsibility."[6] It only makes sense. A story about a family in poverty focuses attention on how to help that particular family, not on the policy decisions that lead to that family being in poverty. Connecting the actions of a politician in Raleigh or Washington to the plight of a particular family is often just too much of a stretch for the average person.

Shifting the Focus: "Sympathy for the Poor" versus "Economic Planning"

More recent research has confirmed and expanded on Iyengar's work. The Ford Foundation has funded extensive research on this topic by the communications firm Douglas Gould & Company.[7] A 2004 survey of 3,205 registered voters compared different "frames" or ways of talking about issues impacting low-wage workers. The "sympathy for the poor" frame, which used the type of classical horror story described above, failed to generate much support for policy fixes. Instead, people felt that the responsibility for solving the problems was incumbent upon the people experiencing the problem.

Researchers then tried what they called the "economic planning" frame. Here they talked about the same problems they had with the "sympathy for the poor" frame, but now they focused on the economy, jobs, and future prosperity. Instead of the horror story, trends and broader influences were used to illustrate the problems. For example, the argument was presented that the nation should not focus on "short-term profits and short-term thinking," but think long-term and "build good-paying jobs with benefits."[8]

The Gould study concluded that moving away from the horror story toward talking about the economy, jobs, trends, and future prosperity significantly increased the public's acceptance of and desire for policy solutions. A recent example of this type of coverage is the wide notice given to retailer Costco for its generous employee benefits, larger contributions to employee health insurance, and low turnover.[9] The theme? Treating your employees well is good for the company, business, customers, and the community.

Other studies involving multiple focus groups, a national study of registered voters, and detailed analysis of news coverage all support the above conclusions.[10-12]

A New Way of Talking about Affordable Healthcare for Everyone

When the predominant way the story of the uninsured is covered in the media is ineffective in building support for policy change, supporters of healthcare for everyone must change their strategy. This means a huge shift in how supporters for change refer to those without health coverage, a change in the examples used to illustrate the need for health coverage, and a relentless focus on the collective responsibility of citizens and government to solve this problem.

First, refocusing media attention from the individual story of the poor uninsured person to the systemic problems that underlie the lack of affordable healthcare should be a top priority. Highlighting solutions is a key part of this effort. Successful collaborations, such as Project Access in Buncombe county,[13] where low-income residents can get comprehensive, affordable healthcare regardless of whether they can afford coverage from work need to be given prominence. Profiles of North Carolina employers who are offering comprehensive healthcare coverage along with decent wages should be used as models. The system is broken—but we have the will and ability to fix it—should be the key message.

Refusing to be drawn into the "find-a-person-without-insurance-to-be-profiled" media trap isn't enough, however. In every story about the lack of affordable health coverage, there should be mention of how this lack hurts the economy, means lack of decent jobs, and imperils future prosperity. To build a strong economy, we need a healthy workforce, and that means everyone needs to be able to see a doctor when they are sick.

We should create jobs in North Carolina, but we shouldn't think short-term. Long-term thinking means creating jobs with good benefits and decent salaries, so people can have a reasonable place to live, connect to their towns and cities, raise their families, and contribute to the future of the community. If families are being driven into bankruptcy by high medical bills that hurts not only them, but our future prosperity. Someone who is bankrupt because of hospital bills isn't going to buy a new car down at the local Ford dealership.

Finally, the way the lack of guaranteed affordable health insurance coverage affects everyone should be made clear. The message here is simple. Why should North Carolinians worry that a job loss or change, a desire to strike out on their own and start a new business, or a sudden disability might mean loss of health coverage for themselves and their families? What kind of

economic engine would we unleash if anyone with a great idea could start a business knowing that affordable health coverage was easily available? How many modern-day Wright brothers are trapped between the need to maintain responsible health coverage from their current company and a dream to strike out and invest in their own innovative ideas?

Fixing Federal Budget Problems Is The Second Component Necessary to Advance North Carolina's Health Agenda

Unfortunately, shifting the message and focus to the economy, jobs, and future prosperity will not be enough to move North Carolina toward affordable health coverage for everyone. A huge roadblock remains in the form of the current devastating fiscal irresponsibility of the federal government. For wealthier states, few prospects of new federal funding for health coverage and increasing federal budget cuts limiting federal healthcare money are not as insurmountable. Massachusetts[14]—with a $52,000 annual median income and a low 11% uninsured rate compared to North Carolina's $39,000 median income and 17% uninsured rate—can credibly move toward universal affordable coverage.[15]

This is not so in North Carolina. Too often, supporters of affordable health coverage for everyone shy away from describing just how to pay for the solutions they proscribe. But building an economy where families don't have to worry about losing affordable health coverage is going to cost money. Sure, if we rebuilt the health system from the ground up, we could probably save enough in administrative, paper-pushing costs to bring everyone in. However, as imperfect and wasteful as our current system is, 85% of the population is more or less happily covered under our current system, and the other 15% isn't marching in the streets for radical change.[a,16]

Indeed, the benefits that more expensive medical care brings—stronger communities, healthier workers, and longer lives—are worth paying for. But, before we look to find more money for expanding care, there remains a huge problem. Current federal tax policies mean that we cannot afford the programs we have in place right now, much less to expand them in the future. A top priority of the President and current Congressional leadership is making tax cuts since 2001 permanent. These tax cuts are disproportionately aimed at top income-earners. People with incomes over $1 million will receive a tax reduction of nearly $112,000 this year, while someone in the middle of the income scale can expect only a $748 reduction.[17] Another priority with broad bipartisan support is to balance the federal budget. As the Center on Budget and Policy Priorities points out, those two goals are simply not compatible without cuts that would be unthinkable to many.

The sad truth is that expanding costs for healthcare combined with drastically reduced tax revenues and an exploding federal deficit mean a sharp fiscal squeeze. Add to this the now nearly $10 billion a month being spent on the war in Iraq and Afghanistan (a cost that has risen almost $2 billion a month in the last year),[18] and it's clear the country is heading for a crisis. In fact, realistic estimates of the budget deficit over the next ten years put the federal government in the red by $4.8 trillion.[19] This is simply unsustainable and puts current healthcare programs like Medicare and Medicaid in serious jeopardy.

One effect of the federal funding crunch is less money to help states facing tough economic times. Over the last several years, multiple states have enacted large cuts in Medicaid eligibility and benefits in response to the economic downturn. Last year, the biggest health issue debated in North Carolina was the proposed denial of Medicaid eligibility to 65,000 elderly, blind, and disabled residents. Although the state's fiscal fortunes seem to be rising in 2006, the same is not true at the federal level.

This year Congress enacted $39 billion in budget reductions, which will mean more people without insurance and will shift billions in child care assistance and welfare reform costs to the states. For example, North Carolina currently is grappling with an unfunded federal mandate to require a birth certificate from the 1.2 million North Carolinians getting healthcare through Medicaid.[20] Finding birth certificates for over a million people on Medicaid who are overwhelmingly elderly, disabled, or under 18 years old is a Herculean task North Carolina's taxpayers will now be expected to finance. Many elderly African Americans, born in a south with segregated hospitals, will have even more difficulty—their "birth certificate" may only be a notation in the family Bible. Cost savings for the federal government translates into huge budget and human costs at the state level.

It's simple. Any honest talk about major expansions in health coverage for North Carolinians has to start with the federal government getting its own fiscal house in order. Otherwise the healthcare coverage debate in North Carolina for the foreseeable future will be about how to preserve current coverage in the face of gigantic federal cutbacks.

What Would it Take to Balance the Budget While Preserving the Tax Cuts?

To balance the budget by 2016 while making the tax cuts permanent, policy makers would have to:

Cut Social Security benefits by 45%

Or cut defense spending by 66%

Or cut Medicare by...56%

Or cut every other program except Social Security, Medicare, defense, and homeland security by 32%

Source: Federal Budget Outlook. Budget presentation. Washington, DC: Center on Budget and Policy Priorities. Available at: http://www.cbpp.org/budget-slideshow.htm. Accessed May 24, 2006.

a Political participation by low-income people (i.e., voting, protesting, contacting legislators, joining advocacy groups, giving campaign donations) is far lower than for people in the middle- and upper-income brackets. This hasn't changed much over the last century.[16]

This political medicine is tough, but necessary, if we want to build a North Carolina economy for the next century where everyone benefits. It will require a balanced, bipartisan approach with strict fiscal rules, reconsideration of ill-advised tax cuts, and an honest assessment of where substantial savings can be made in Medicare and Medicaid spending. This is a contentious process, but some ways to start would be:

- Reinstate "pay-as-you-go" rules that require Congress to pay for all tax cuts and increases in entitlement programs before such tax cuts or increases can be enacted.
- Don't make permanent any tax cuts that are not clearly paid for.
- Rethink tax cuts going to people with annual incomes over $400,000—the top 1% of the population—and devote resulting revenues to reducing the federal budget deficit and strengthening Medicare and Medicaid.
- Revise the Medicare Part D prescription drug legislation to allow the federal government to negotiate directly with drug companies and obtain the lowest possible prices for drugs.
- Invest in research that compares the effectiveness and value of prescription drugs, healthcare procedures, and other health initiatives.

A Positive Outlook for a Strong Future Economy

As our technology becomes more sophisticated, our population ages, and our state population grows, we face a critical choice. A strong future North Carolina economy means good jobs with quality benefits and access to the best and most innovative healthcare that the many medical resources in our state have to offer. A long and healthy life should be attainable for every North Carolinian whether they work in a tourism job on the coast or a research and development job in the Research Triangle Park. A big part of creating the economy and prosperity people want is ensuring affordable healthcare coverage for all. This is an attainable goal, but two necessary steps on the road to reform require rethinking the message around affordable healthcare coverage and demanding true fiscal accountability from the federal government. **NCMedJ**

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Task Force members included: **Carmen Hooker Odom, MRP**, Secretary, NC Department of Health and Human Services (co-chair); **Thomas Lambeth**, Senior Fellow, Z. Smith Reynolds Foundation (co-chair); **Rep. Jeff Barnhart**, NC General Assembly; **Andrea Bazan-Manson, MSW, MPH**, President, Triangle Community Foundation; **Mark T. Benton**, Senior Deputy Director and Chief Operating Officer, Division of Medical Assistance, NC Department of Health and Human Services (NC DHHS); **Millie Brown**, Director, Duplin County Department of Social Services; **H. David Bruton, MD**, former Secretary, NC DHHS; **Sonya Bruton, MPA**, Executive Director, NC Community Health Center Association; **Barbara Morales Burke, MHA**, Chief Deputy Commissioner, NC Department of Insurance; **Pearl Burris-Floyd**, Gaston County Commissioner; **Timothy S. Carey, MD, MPH**, Professor of Medicine and Director, Cecil G. Sheps Center for Health Services Research, UNC at Chapel Hill; **J. Keith Crisco**, President, Asheboro Elastics Corp.; **Leah Devlin, DDS, MPH**, State Health Director, NC DHHS; **L. Allen Dobson, Jr., MD**, Assistant Secretary for Health Policy and Medical Assistance, NC DHHS; **Victor J. Dzau, MD**, Chancellor, Duke University Medical Center; **Rep. Beverly Earle**, NC General Assembly; **Allen Feezor, MA**, Chief Planning Office, University Health Systems of Eastern Carolina; **Charles T. Frock**, Chief Executive Officer, FirstHealth of the Carolinas; **Robert Greczyn, Jr.**, President and CEO, Blue Cross and Blue Shield of NC; **Ches Gwinn, MPA**, Co-Chair, NC Health Insurance Innovations Commission; **Billy Ray Hall**, President, NC Rural Economic Development Center; **Sen. Fletcher L. Hartsell, Jr.**, NC General Assembly; **Ann Holton**, Pamlico County Commissioner; **Rep. Verla Insko**, NC General Assembly; **Robert Jackson**, State Director, NC Office, AARP NC; **Connie Majure-Rhett, CCE**, President and CEO, Greater Wilmington Chamber of Commerce; **John B. McMillan, JD**, Manning, Fulton and Skinner, PA; **John Mills**, former Executive Director, NC Association of Free Clinics; **David Moore, CLU**, Past President, NC Health Underwriters Association; **Graham T. Moore, Jr.**, Vice-President of Marketing and Area Operations Manager, APAC-Atlantic, Inc. Coastal Carolina Division; **Aaron Nelson**, Executive Director, Chapel Hill-Carrboro Chamber of Commerce; **Sen. Martin L. Nesbitt, Jr., JD**, NC General Assembly; **Rep. Edd Nye**, NC General Assembly; **Mary Margaret "Peg" O'Connell, JD**, Director of External Relations, The Carolinas Center for Medical Excellence; **Barbara Pullen-Smith**, Director, Office of Minority Health and Health Disparities, NC DHHS; **William Pully, JD**, President, NC Hospital Association; **Sen. William Purcell, MD**, NC General Assembly; **Sen. Tony Rand, JD**, NC General Assembly; **Rep. Karen Ray**, NC General Assembly; **James T. Roberson, Jr., PhD**, Dean, Shaw University Divinity School and Pastor, New Bethel Baptist Church; **Jack Rodman**, President and CEO, NC Business Group on Health; **William Roper, MD, MPH**, Dean, UNC School of Medicine and CEO, UNC Health Care System, UNC at Chapel Hill; **Eric Russman, JD**, Vice President and Executive Director, UnitedHealth Group Center for Affordable Consumer Health, **Randy Rust**, President, Rust Enterprises/McDonald's; **Wanda Sandelé**, Health Director, Craven County Health Department, **Adam Searing, JD, MPH**, Project Director, NC Health Access Coalition; **Stephen T. Smith, JD**, Program Associate, NC Council of Churches; **Russ Stephenson**, President and CEO, Stephenson Millwork Company; **Sen. A.B. Swindell IV**, NC General Assembly; **Judith E. Tintinalli, MD, MS**, Professor and Chairman, Department of Emergency Medicine, UNC School of Medicine; **Lynette Rivenbark Tolson**, former Director of Advocacy, American Heart Association; **Torlen Wade**, Director, NC Office of Research, Demonstrations, and Rural Health Development (ORDRHD), NC DHHS; **Charles F. Willson, MD**, President, NC Medical Society, Clinical Professor, Brody School of Medicine; **Leslie Winner, JD**, Vice President and General Counsel, General Administration, UNC at Chapel Hill; **Rep. Thomas Wright,** NC General Assembly; **Doug Yarbrough, MBA**, President and CEO, Duplin General Hospital, Inc.

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1 North Carolina Institute of Medicine. Expanding Health Insurance Coverage to More North Carolinians. Durham, NC. April 2006. Available at: http://www.nciom.org/projects/uninsured/uninsuredreport.html. Accessed May 8, 2006.

The Task Force was a collaborative effort of the North Carolina Department of Health and Human Services, the North Carolina Department of Insurance, the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill, and the North Carolina Institute of Medicine. The Task Force was generously funded through a one-year State Planning Grant from the Health Resources and Services Administration of the United States Department of Health and Human Services. The primary staff direction of the overall State Planning Grant Task Force work was the responsibility of Dennis Williams, Associate Director, and Anne Braswell, Senior Analyst, of the Office of the Research, Demonstrations, and Rural Health Development, NC DHHS.

Running the Numbers

A Periodic Feature to Inform North Carolina Healthcare Professionals about Current Topics in Health Statistics

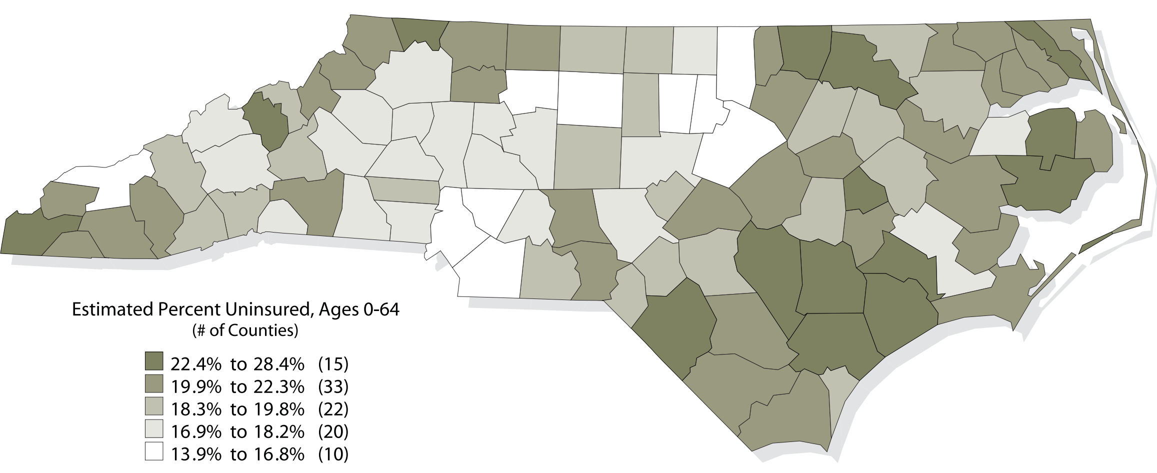
From the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill
http://www.shepscenter.unc.edu

The Uninsured in North Carolina, 2004

Estimating the number of uninsured at the county level is not a straightforward process because there are no direct surveys at the local level. Analysts at the Cecil G. Sheps Center for Health Services Research have used data from the United States Census Bureau's Current Population Survey (CPS) March Supplements from 1995-2005 to create county-level estimates of the numbers of persons under 65 years of age who were without insurance for each year starting in 1999. The maps displayed here summarize the results for 2004.

This estimation process identified the factors associated with being uninsured in the state-level sample then extrapolated those data using full population data for each of the counties. Those data indicate that, in general, people who lack health insurance in North Carolina are more likely to be poor, younger, or employed in small business. These factors, among others, were then used to create local estimates. For example, if 20% of males and 10% of females working in service industry jobs in North Carolina are uninsured, then these rates can be applied to county level employment and age-gender characteristics to generate an estimate of the rate of uninsured in a particular county The complete report, including a listing of counties with numbers and percent of population uninsured, is available at http://www.shepscenter.unc.edu/.

Percent of North Carolinians Aged 0-64 without Health Insurance
Estimates for 2004



Produced by: Program on Health Economics and Finance, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.
Source: Synthetic estimates based on Annual Social Economic Supplement, US Census Bureau, 2004-2005.
Full report available at http://www.shepscenter.unc.edu.

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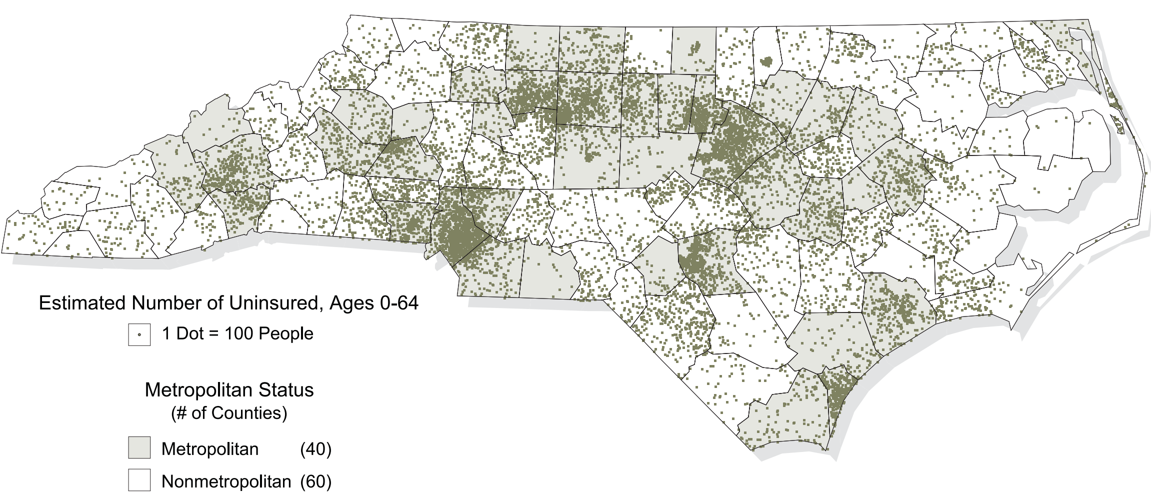
The maps show that higher proportions of the population in the more rural areas of the eastern part of the state and the northern and southern mountain counties are more likely to be uninsured with a notable "cluster" of high rates in the region including Onslow, Jones, Duplin, Sampson, and Pender counties. The second map indicates that the absolute numbers of uninsured are concentrated in the urban counties. The problem of uninsurance is a statewide phenomenon with rates and numbers showing slightly different effects across the state. Since some areas of the state have lower average incomes or more employees of small businesses, these areas will generally have more uninsured people. Policymakers may wish to focus efforts in areas with particularly low insurance coverage rates. Local healthcare providers may better demonstrate the extent of their need for government and philanthropic support using estimates of local uninsured populations.

Number of Residents Aged 0-64 without Health Insurance
North Carolina, 2004



Produced by: Program on Health Economics and Finance, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.

Sources: Uninsured Data—Synthetic estimates based on Annual Social Economic Supplement, US Census Bureau, 2004-2005. Metropolitan Status—US Census Bureau and Office of Management and Budget, 2003.

Full report available at http://www.shepscenter.unc.edu.

Note: Dots are scattered randomly throughout zip code areas and are not intended to locate a particular place or population.

Contributed by Thomas C. Ricketts III, PhD, MPH, and G. Mark Holmes, PhD
Cecil G. Sheps Center for Health Services Research
University of North Carolina at Chapel Hill

Readers' Forum

To The Editor:

As Chief of the North Carolina Division of Social Services' (DSS) Family Support and Child Welfare Section, I value the commitment and efforts of our university and medical partners and sister agencies in the North Carolina Department of Health and Human Services. We all diligently strive to achieve the safety, permanence, and well-being of children and their families. The commentary written by Dr. Adam J. Zolotor, Dr. Desmond K. Runyan, Ms. Brenda Motsinger, and Ms. Catherine Sanford published in the September/October 2005 volume of your Journal, entitled "Building an Effective Maltreatment Surveillance System in North Carolina" had several points that I agree with and support. One of these is that "coordinated efforts and a variety of data sources from multiple sectors" are critical to developing a child maltreatment surveillance system. The North Carolina Division of Social Services supports this endeavor through participation in the Families Accessing Services through Technology (NC FAST) program. When fully implemented, it will provide for efficient, effective assessment; comprehensive case management; and better evaluation information through its comprehensive outcomes data and capacity to ensure accountability across programs. As a result, I agree that this system will "improve the consistency of data collection and allow data to be compared more easily among counties."

The commentary continues to state that "for each report that is accepted to the department of social services for a family or investigative assessment, the family's needs are now assessed using a standardized risk assessment tool," which leads the reader to believe the use of standardized assessment tools is a new development. The Division implemented the use of Structured Decision Making tools in the county Departments of Social Services on April 1, 2002. These tools were adopted to achieve greater consistency among our child welfare staff in providing on-going safety and permanence for children and families. Our use of those tools over almost four years has guided our case decision-making and helped us better achieve the outcomes of safety, permanence, and well-being of children.

The authors are correct that domestic violence is a risk factor for child abuse. Their statement that "…DSS has recently implemented a policy to accept all reports of witnessed domestic violence for investigation" seems to infer this is new to our system. Our Structured Intake policy guides our intake and screening decisions and became effective June 1, 2003.

We believe that child maltreatment and adult domestic violence often occur together. In September 2004, we established a separate section of our Child Protective Services (CPS) policy manual to provide the specific information and protocol that addresses the intersection of child safety, permanence, and well-being and domestic violence. This policy was developed in collaboration with the state's domestic violence community. It establishes the primary focus of child protection intervention in cases involving domestic violence as the ongoing assessment of the risk posed to children due to the presence of violence in their families. It, in combination with our Structured Intake policy, establishes that the DSS does not accept all reported cases involving domestic violence. A CPS report in which the *only* allegation is domestic violence does not meet the statutory criteria for child abuse, neglect, and dependency.

This article's statement also leads one to believe that workers make CPS assessment case decisions independently. This is not accurate or supported by policy that has guided CPS practice for many years. Policy clearly states, "the CPS assessment case decision must be a shared decision, including at a minimum, the worker and the workers' supervisor or supervisor's designee or staffing team."

I appreciate the authors' efforts in serving children and their families. Without them, and others like them, North Carolina's children would be much less safe than they are today. I am honored to partner with them in our continued collaborative efforts. Thank you for the opportunity to offer some insight on some of our policy and practice points. I am available to answer questions or further explain our CPS system.

Jo Ann Lamm, Chief
Family Support and Child Welfare Services Section
North Carolina Division of Social Services
North Carolina Department of Health and Human Services

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